Exploring Communication Processes During Transitions from Acute Care to Skilled Nursing Facilities and Perceived Barriers to Communication

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Exploring Communication Processes During Transitions from Acute Care to Skilled Nursing Facilities and Perceived Barriers to Communication

By Marrizzia Oxford

Dissertation Committee:
Dr. Genevieve Zipp (Chair)
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Submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Health Sciences
Seton Hall University
2021
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SETON HALL UNIVERSITY
School of Health and Medical Sciences

APPROVAL FOR SUCCESSFUL DEFENSE

Doctoral Candidate, Marrizzia Oxford, has successfully defended and made required modifications to the text of the doctoral dissertation for the Ph.D. during the Spring Semester 2021

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ABSTRACT

Exploring Communication Processes During Transitions from Acute Care to Skilled Nursing Facilities and Perceived Barriers to Communication

Marrizzia Oxford

Seton Hall University, 2021

Dissertation Chair: Dr. Genevieve Pinto Zipp

Background and Purpose of the Study: The need for skilled care and long-term care services often becomes necessary as the older adult transitions into the golden years. In the United States, more than 1.5 million adults live in long-term care facilities, with this number expected to double by 2050 (Johnson, Pope joy & Radina, 2010). Effective communication between the healthcare professionals who refer individuals from an acute care setting to a skilled nursing facility can be challenging and ultimately impact their transfer status and Plan of Care (POC) or plan of action implementation for meeting healthcare goals of the patient (Benzar et al, 2011, CDC, 2020). The purpose of this qualitative research study is to explore the communication initiatives (processes) employed as part of the transition process from the acute care to long term care setting, in order to promote patient POC and quality of care.

Methods: The focus of this general qualitative study was to employ a descriptive research design using qualitative interviews. An inductive approach was used to collect data relevant to the topic
of interest and patterns in the data were used to develop a theory that could explain those data. The aim of the study was to explore communication barriers between acute care and skilled care settings professionals in the transition process. A sample of 7 healthcare professionals across acute-care and skilled care settings participated in this study.

**Results:** Qualitative thematic analysis resulted in 6 overarching themes: 1) The transition teams’ perceived communication initiatives include written and verbal communication employed among the teams to exchange vital information can be challenging and impact the transfer status. Insufficiency, and clarity issues are important to identify early within the transfer process. Daily meetings help eliminate obstacles and establish key issues within patient medical history. 2) The transition teams’ perceived barriers center around skilled care facility requirements. Additionally, there are time delays, diverse issues with patient needs, and problems with information retrieval. Management routine communication practices helps improve transfer process. 3) The transition teams’ perceived pressures are the facility’s time sensitivity issues, limited facility policy and communication between acute care setting and the skilled care facility leading to errors such as improper discharge. 4) The Transition teams’ perceived benefits centers around an effective team based plan of care, person centered care and creating patient initial assessment which fosters teamwork for the patient overall health and quality of life. 5) The transition team’s perceived key acuity measures include measuring discharge planning by employing HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) which is designed to enhances scores on internal set criteria as well as enhance scores on external criteria which allows the team to concentrate on facility policies for smoother transitions and reduces the length of stay by positively impacting the effectiveness of patient satisfaction in the
transition process. 6) The transition teams’ experiences are often stressful but communication practices, education and knowledge, trial, and error support better decision-making outcomes.

**Conclusion:** Written and verbal communication, policies and procedures, facility time sensitivity issues, effective communication, setting realistic goals for the patient and the team collaboration are important components in the transitioning process. The journey from hospital to sub-acute or long-term care facility can become an involved task for everyone responsible for both direct and indirect patient care. As acute care hospitals discharge patients back to the community and/or refer patients to skilled facilities for sub-acute care and/or long-term care, a team of experts must be present for this transition of care and aid in the communication necessary to uphold quality. Effective communication is the foundation for successful outcomes and quality of life when the patient transitions from acute care to skilled nursing facility. Future research should focus on a potential case study over time and/or survey research utilizing the Delphi technique to gauge a larger transition team member population and/or inclusion of more facilities for comparison purposes from additional states within the U.S and/or international populations.

**Keywords:** quality of care, long-term, skilled nursing facility (SNF), transitioning, communication, aging
ACKNOWLEDGMENTS

There are a countless number of individuals who have made this accomplishment possible in executing the first and last of many dissertation drafts that lead me to completion of obtaining a Ph.D. I’m deeply and profoundly excited in acknowledging my dissertation committee members.

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DEDICATION

This dissertation research is dedicated first to GOD our Father and our LORD JESUS CHRIST in which I give all the glory.

My husband, Duane, who is my ROCK, my equal partner, who inspires me to be the very best - I thank the Lord for giving me this wonderful and intelligent man as a gift from childhood. My husband always says there is nothing we can’t accomplish together. Also, to my parents who provided me with the will to be greater than what I am. I feel your presence everyday Mommy and Daddy! I miss both of you dearly. I DID IT! THANK GOD!
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Chapter I
INTRODUCTION

Background of the Problem

The provision of quality healthcare for patients regardless of the healthcare setting (acute, sub-acute and long-term) is the primary goal of all healthcare providers. Although the patients’ plan of care within each healthcare setting is uniquely influenced by several factors including the patients’ needs and abilities, the patients’ level of acuity, the experience of healthcare professionals and the resources available to carry out the plan of care, effective communication is a key indicator of quality healthcare provision.

As our aging population continues to grow, the number of individuals (patients) being admitted to the long-term healthcare setting also continues to grow. As our aging population transitions from acute care settings to long term settings, continuity of quality healthcare must be maintained. Often, effective communication between the referring acute care setting and the receiving long-term healthcare setting can be challenged and negatively impact the transfer and implementation of the patient healthcare plan (Davis et al, 2005). The degree or level of communication during this transition period may be an indicator of the quality of the individual’s future healthcare (Benzar et al, 2011). In the literature, the absence of data on communication processes and practices during this transition period and its possible impact on the quality of care in long-term healthcare settings presents a gap of unknowns.

Statement of the Problem

Patient handovers transfer responsibility for the patient among healthcare teams in different clinical settings, with missed information potentially placing patients at risk for adverse
events. Thus, effective communication between the referring acute care unit and the skilled nursing facility is of paramount importance and the degree or level of effective communication during this transition period may be an indicator of quality healthcare (Bensign, 1991). The absence of data on the communication processes employed during this transition period and the impact on quality of care in the long-term healthcare setting presents a problem for patients and healthcare providers seeking to ensure quality of care along the healthcare continuum.

**Purpose of the Study**

The purpose of this qualitative research study was to explore the communication initiatives (processes) employed as part of the transition process from the acute care to long term care setting, in order to promote patient POC and quality of care.

**Variables**

The independent variable in this study is the type of transition team member (acute care discharge managers, nursing home social workers, nurses and directors) with varying years of experience. The dependent variable in this study is the communication processes.

For the following research questions Skilled Nursing Facilities (SNFs) refer to nursing and therapy care that can only be safely and effectively performed by, or under the supervision of, professionals or technical personnel. It is health care given when you need skilled nursing or skilled therapy to treat, manage, and observe your condition, and evaluate your care (Medicare.gov, 2019).
Research Questions

Central Research Questions:

1. What are the communication initiatives (processes) employed by the transition team as part of the transition process from the acute care to SNF setting, in order to promote patient POC and quality of care?

2. What do the transition team members perceive as barriers to effective communication?

Sub-Research Questions:

RQ1: What are the transition teams’ perceived communication initiatives (processes) employed as part of the transition process from the acute care to SNF setting, in order to promote patient POC and quality of care?

RQ2: What are the transition teams’ perceived barriers associated with communication among the team during the patient’s transition process from acute care to SNF setting?

RQ3: What are the transition teams’ perceived pressures associated with communication among the team during the patient’s transition process from acute care to SNF setting?

RQ4: What are the transition teams’ perceived benefits associated with communication among the team during the patient’s transition process from acute care to SNF setting?

RQ5: What are the transition teams’ key acuity measures used during the patient’s transition process from acute care to SNF setting, in order to promote patient POC and quality of care? And why?

RQ6: What are the transition teams’ communication experiences as part of the transition team from the acute care to SNF setting?
Rationale of the Study

Communication can either aide or hinder the effective transitioning of patients POC from acute care setting to SNF, which can further impact patient quality of life by increasing acute care readmission (Mileski et al. 2017), increase mortality rates (Burke et al., 2016), increase financial burdens (Mileski et al. 2017), increase mortality rates (Burke et al., 2016), and increase social burden (Zimmerman et al., 2008). Thus, research specifically addressing communication processes and practices during transitioning from acute care to the SNF can promote an awareness of the issue and lead to potential innovations to positively address communication practices and issues.

Operational Definitions

The following terms will be used throughout the chapters of this manuscript:

- **Skilled Care** (i.e. Skilled Nursing, SNF): nursing and therapy care given when you need safe, effective and skilled therapy which treats, manages, observes and evaluates (medicare.gov, 2019)

- **Long-term care**: health services for individuals and populations that increase the likelihood of desired health outcomes which are consistent with current professional knowledge (Institute of Medicine, 1990)

- **Transitional care**: services or set of actions designed to ensure the coordination and continuity of healthcare while patients transfer between different levels of care among a diverse range of providers, services and settings (Coleman, 2003; Naylor, 2002)
• **Acute care**: The health system components, or care delivery platforms, used to treat sudden, often unexpected, urgent, or emergent episodes of injury and illness that can lead to death or disability without rapid intervention (Who 2012).

• **Quality**: attributes or properties of the process of care and others as goals or objectives of that process (Lee and Jones, 1993)

• **Acuity**: the measurement of the intensity of nursing care required by a patient. An acuity-based staffing system regulates the number of nurses on a shift according to the patients’ needs, and not according to raw patient numbers (Foster 2017)

• **Quality initiatives**: build on the existing work in long-term and post-acute settings while improving quality of care (CMS, 2008)

• **Quality indicators**: performance, process, and outcomes of measures in quality of care (Castle and Ferguson, 2010)

• **Health communication**: is the study and practice of communicating promotional health information, such as in public health campaigns, health education, and between doctor and patient. The purpose of disseminating health information is to influence personal health choices by improving health literacy (CDC 2020).

• **Plan of Care**: A nursing care plan is a plan of action for the care of a patient. In following the nursing process, after assessing and diagnosing a patient, the nursing care plan is created to take steps to meet the patient and health care team’s goals for the patient’s health (CDC 2020).

• **Quality health care** is “safe, effective with help, patient-centered, timely, efficient and equitable” (Institute of Medicine (IOM) of the National Academy of Sciences 1990).
Quality healthcare for patients regardless of the healthcare setting (acute, sub-acute and long-term) is the primary focus of all healthcare providers (Grabowski, 2007).

- **Quality health care** “as doing the right thing for the right patient, at the right time, in the right way to achieve the best possible results.” (Agency for Healthcare Research and Quality (AHRQ) (Grabowski, 2007).

- Patients **plan of care (POC)** are influenced by the needs and abilities of the patient, healthcare professionals experience level and the resources (setting/personal) available to carry out the plan of care (Davis et al, 2005).

- **Effective communication** is key for the provision of quality healthcare (Benzar et al., 2011).

**Conceptual Framework**

According to Barnlund’s Transactional Model of Communication (Figure 1), communication is a process in which communicators generate social realities within social, relational, and cultural contexts (Barnlund, 1970). We do not just communicate to exchange messages; we communicate to create relationships, form intercultural alliances, shape our self-concepts, and engage with others in dialogue to create communities. The roles of the sender and receiver in the transaction model of communication differ significantly from other models. Instead of labeling participants as senders and receivers, the people in a communication encounter are referred to as communicators. Furthermore, unlike the interactive model, which suggests that participants alternate positions as sender and receiver, the transaction model suggests that we are simultaneously senders and receivers. This is an important addition to the model because it allows us to understand how we are able to adapt our communication—for
example, a verbal message—in the middle of sending it based on the communication we are simultaneously receiving from our communication partner (Barnlund, 1970). The transaction model of communication describes communication as a process in which communicators generate social realities within social, relational, and cultural contexts. In this model, we do not just communicate to exchange messages; we communicate to create relationships, form intercultural alliances, shape our self-concepts, and engage with others in dialogue to create communities. (Barnlund, 1970).

Barlund’s Transactional model reflects on two types of communication processes: Intrapersonal is the process of encoding/decoding one’s own messages (e.g. reading a book) and Interpersonal is the process of encoding/decoding another person’s messages (e.g. teamwork). Behavioral Cues are also involved which include verbal (i.e. orally spoken) and nonverbal (e.g. gestures, body cues) (Barlund, 1970).

According to Dean C. Barnlund communication is defined as "a word that describes the process of creating a meaning" (Barnlund, 1970). Based on Barlund theory’s Communication Postulates, communication describes the evolution of meaning, Communication is dynamic, continuous, circular, unrepeatable, complex, and irreversible (Barnlund, 1970).

In this study, the transaction model of communication will be used as a framework to explain how individuals guide and engage in conversations between each other in group settings. The theory also helps to explain non-verbal cues by using non-verbal communication. The theory helps frame the dissertation study by acknowledging that there is an open dialogue between the sender messenger and receiver. Communication creates connections which can prompt actions to be transported. Therefore, any issues in these connections creates a disconnect which can cause problems such as during transitional stages of patient care which, in turn, affects quality.
Figure 1.

Barnlund’s Transactional Model of Communication

(Barnlund, 1970)
Chapter II

REVIEW OF RELEVANT LITERATURE

In order to understand communication processes during transitions from acute care to skilled nursing facilities, we must first understand the types of care that are present within the healthcare system. Several different types of care exist in the literature that aid in the discussion of the problem and disconnect that exists and evaluating these types of care sets the stage for the communication issues present within the aforementioned problem statement.

Long-Term Care

In the literature, long-term care is used interchangeably with the term nursing home. The Institute of Medicine (1990) defines long-term care as health services for individuals, aging adults or populations that increase the likelihood of desired health outcomes which are consistent with current professional knowledge. In general, long-term care health services are designed to meet the health and personal needs of the patient (Kane 2001). The literature is transparent in that there is no congruent definition for long-term quality of care. Long-term care refers to any personal care and assistance that an individual might receive on a long-term basis because of a disability or chronic illness that limits his or her ability to function (Kane & Kane, 1987; Kane, Kane, & Ladd, 1998). Long-term care terminology is constantly changing in healthcare. The currency of language easily becomes tarnished and soon, perhaps, the term “long-term care” will be passé. “Long-term services” has been a preferred term among some people with disabilities (National Institute for Long-Term Services, 1996). The Robert Wood Johnson Foundation has grouped its long-term care efforts for people of all ages under the umbrella term “supportive services.” But whatever it is called, long-term care is the mixture of concrete tasks that enable a person with a disability to flourish as much as possible despite that disability (Kane 2001).
**Quality and delivery.** There are formal definitions of how quality is defined in the literature. However, many of the researchers, and healthcare professionals, and medical institution view quality through a certain lens or prospective.

The Centers for Medicare & Medicaid Services CMS (2008) defines “long-term quality” in healthcare as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.” With an overwhelming number of researchers, as well as organizations seeking to find the most arbitrary definition to explain what “quality” is, Donabedian is recognized as the forerunner in providing the benchmark description. As directly cited from his work in 1966, Donabedian states, “As such, the definition of quality may be almost anything anyone wishes it to be, although it is, ordinarily, a reflection of values and goals current in the medical care system and in the larger society of which it is a part” (Donabedian, 1966). He expands that quality in long-term care has a monitoring system which was originated to track major issues ranging from infection control, patient rights, environment staffing concerns, and the one perceived as most important - quality of life. Such standards surrounding these areas were formulated to provide direction and regulate the deliverance of care to patients. Donabedian (1966) attempted to make sense of how other theorists in the field define “quality” in the area of medical care. Quality in long-term care has been a growing problem for many years and the professionals in the field seem to attribute knowledge and communication as essential factors to provide quality of medical care.

According to Zhang & Grabowski (2004), Congress passed the Nursing Home Reform Act (NHRA) as a part of the Omnibus Budget Reconciliation Act of 1987 with the goal of improving the quality of care in nursing homes through greater government regulation. While the
NHRA serves an important role for improving quality care in nursing homes, the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) requires that nursing homes and all other post-acute care facilities submit standardized data with regard to quality domains including skin integrity, functional status and cognitive function, medication reconciliation, incidence of major falls, and transfer of health information and care preferences when an individual transitions (Kapoor et al, 2019). As new policies continue to regulate quality within the areas of skilled care facilities, it is necessary to understand that quality is recognized across all transitions from acute care to skilled care facilities. Also, the IMPACT Act only mandates data collection for the receiving post-acute care facilities. To improve care coordination and enhance discharge planning, hospitals also need to collect data and transmit those data in standardized fashion. The IMPACT Act supports the CMS initiative Meaningful Measures, which introduces several priority areas to improve quality in post-acute care (Kapoor et al, 2019). As these procedures are facilitated through the acute care and skilled care facility, the literature continues to state that communication challenges impede the transition process. While it is not unusual that new policies will continue to evolve and change the transition process, the goal is for acute care and skilled care facilities to adhere to all policies and procedures that guide the team members’ behaviors during the patient transition period and also to understand that communication barriers exist solely because team members fail at adapting and or implementing policies and procedures correctly through the patient transition process. Kapoor et al. (2019) states “The most relevant of these for ensuring safety during transition from hospital to LTC include promoting effective communication and coordination of care; making care safer by reducing harm; and strengthening of person and family engagement as partners in patient care.” Communication is key in determining safe transitions. The majority of the
literature also states that patients are not a part of the decision-making process when the patient needs to transfer from acute care to skilled care facility. The transition process begins with the decision to send a patient to an SNF, rather than discharge to home. It also involves the identification of a specific facility to continue patient care. Hospital providers reported significant pressure to optimize length of stay and discharge patients who no longer required inpatient hospital services. Using an SNF helped them expedite safe discharges, particularly for patients who had become deconditioned in the hospital or who had limited support available at home. A hospital physician stated, “From the perspective of the medical team, it is much easier, and orders of magnitude are easier to get someone to a facility than it is to get them home. . . especially when they’re elderly, frail, and sick” (Britton et al., 2017). Transition team members try to eliminate such transitional barriers and the majority of the time such difficulties begin at the admission process. According to Britton et al. (2017), nearly one-fourth of events occurred on the day of discharge or the day after, suggesting that the resident was prematurely discharged. There is concern that the hectic hospital environment with focus on decreasing length of stay and could increase the risk of adverse events. In addition, posthospitalization syndrome, “a pathophysiologic syndrome of weakness and increased stress” may leave patients more vulnerable to adverse events. Development of strategies to better assess readiness for discharge may alleviate some of the transition-related adverse events. Engaging hospitals and their medical staff to better understand the capabilities and challenges confronting LTC facilities would also be important and has been advocated in recent scientific studies (Kapoor et al, 2019).

SNF admission strategies may depend on the strength of their hospital relationships and referral patterns. Staff members at SNFs and hospitals have historical relationships that develop over time and color how they perceive each other’s willingness to accept referrals and each
other’s capacities to care for complex patients. Depending on the strength of their relationships, such as the volume of referrals SNFs have with area hospitals, SNFs use different strategies both for screening out potential admissions considered less preferable and casting a wide net to attract as many admissions as possible for financial viability (Shield et al, 2018). In late 2019, the US Centers for Medicare & Medicaid Services announced a rule related to the Medicare Post-Acute Care Transformation Act that post-acute rehabilitation service sectors must empower and engage patients to actively participate in their discharge planning. This rule is intended to reduce patients’ chances of rehospitalization after transitioning home from the hospital or other post-acute rehabilitation services (Tzeng & Okpalauwaekwe, 2020). The NHRA and IMPACT ACT OF 2014 mandated the most comprehensive legislative requirements to date in terms of the provision of nursing home care. The Binstock & Spector (1997) article, “Five priority areas for research on long-term care,” accurately provided the top areas on importance referencing the aspect of quality when detailing long-term care. “For long-term care there are special problems in measuring quality. First, the care recipient is often incapable of evaluating the quality of care and communicating concerns about it because of cognitive deficits” (Binstock & Spector, 1997). Both authors are clearly outlining the cognitive disfunction that occurs on behalf of the patient being subjected to long-term care. At this level, evaluation of care cannot be determined as the patient experience is often misperceived individually.

Lievesley, Crosby, & Bowman (2011), in a 2009 survey of BUPA care homes, the second largest provider in the UK, found 90 percent of the residents presented with at least one of the following: total dependence in mobility, severe hearing or visual impairments, dual incontinence, dementia, confusion or challenging behavior. These authors believe there is a disconnect in
determining what the most appropriate care plan assessment is to use when making proper decisions for the quality of the patient based on so many diagnoses.

There are three categories of quality to produce a better outcome for the patient: structure, process, and outcome (Donabedian, 1998). Structure denotes the attributes of the settings (facilities, equipment, and money) in which care occurs. Process denotes what is done in giving and receiving care and includes the patient’s activities in seeking care. Outcome denotes the effects of care on the health status of patients and populations. Improvements in patient’s knowledge and salutary changes in the patient’s behavior are included under a broad definition of health status (Donabedian, 1998).

Binstock & Spector (1997), Donabedian (1988), Kane et al., (2003), and Lievesley et al. (2011) overall agree and suggest providing quality to patients centers around improving the healthcare assessment, providing proper management, structure, process and outcomes to increase the likelihood of improving the quality of the patient. According to Binstock & Spector (1997), the second priority centers around the family member who may be very involved in managing, monitoring, and providing care; hence, the consumer/provider distinction may be blurred, making it difficult to measure satisfaction with care. The authors suggest that often when the involvement of a family member is present, the quality of care may or may not be accurately determined because emotions are high from family members which may interfere with the appropriate course of action or timing of that action, especially when the family members are not healthcare professionals who understand the processes involved (Binstock & Spector, 1997).

The third priority and factor impacting quality of care includes the complexity of care needs and the common existence of many comorbidities among long-term care recipients, which makes it difficult to develop useful disease-specific outcome measures. Binstock & Spector
(1997) suggest long-term care patients often have multiple diagnoses leaving evaluation of care difficult to determine. A convergence of individual disease-specific state outcomes is hard to derive in a long-term care environment where the majority of the patient population suffers from multiple ailments. Luchi, Gammack, Narcisse & Storey (2003) state that outcomes that may be expected from comprehensive geriatric assessment include greater diagnostic precision, increased function, reduction in polypharmacy, and increased patient and family satisfaction. According to Binstock & Spector (1997), a fourth factor is population diversity in long term care settings. Thus, the nature and scope of quality concerns may vary considerably in accordance with the specific goals of the care setting and the level of functioning of the resident. Each patient has individual goals dependent upon several factors, including disease state, length of stay, and therapeutic intervention. Every patient has an individual background with different requirements which set the plan of care, reliant on such mentioned factors (Binstock & Spector, 1997).

Luchi et al. (2003) recommends that primary prevention is the most important portion of delivery to quality of care. Primary prevention is defined as preventing the development of a disease or disability. Secondary prevention refers to the early detection of disease and prevention of its progression or recurrence. Luchi et al. (2003) states that research on quality in long-term care must begin at the most fundamental level which is in the acute care setting and must include both primary and secondary preventative care practices.

According to Binstock and Spector (1997), the ongoing provision of long-term care is critically challenged. A number of major societal dynamics indicate that the need for long-term care in the years immediately ahead will grow tremendously. Yet, concomitantly, the delivery of services with appropriate quality may become increasingly problematic as policymakers strive to
curtail the growth of public subsidies for such care and as marketplace incentives changes (Kane 2001).

As patients continue to transition from acute care hospitals to a long-term care environment, the demand for quality of care at this juncture is imperative to the patient’s ongoing healthcare journey. While 29 percent of the long-term care population resides in an institutional setting (e.g. nursing homes), 71 percent live at home in their community (Doty, Liu & Wiener, 1985). Residents of institutions are generally more disabled than dependent elderly in the community, yet for every person 65 years of age and over residing in a nursing home, there are twice as many persons living in the community requiring similar levels of care (Doty, Liu & Wiener, 1985).

Long-term care facilities not only specialize in rehabilitation services but the overall deliverance of care such as psychological, sociological, activities of daily living, environmental and religious functioning (Binstock & Spector, 1997). According to Doty, Liu & Wiener (1985), long-term care is characterized by medical, personal, social, and psychological care over extended time periods. The need for long-term care is not necessarily identified by diagnoses or diagnostic characteristics, but rather based upon physical and/or cognitive (mental) abilities that impact the person’s level of functional independence with activities necessary for daily living (Doty, Liu & Wiener, 1985).

Although concerns associated with physical and/or cognitive abilities can negatively impact individuals of all ages, the need for long-term care strongly increases with age. Additionally, the type of long-term environment for which the patient is recommended is further determined by the multifaceted deliverance of care needed by the interprofessional healthcare team and the resources available at the long-term care sight (Castle and Ferguson, 2010)
Quality of care in long-term care is a complex concept confounded by regulations and debates about what should be measured to assess quality (IOM, 1986). Numerous definitions of quality exist in the literature but defining quality specifically in long-term care has been an arduous process for medical professionals and researchers in the field. It is defined both as an input measure and as an outcome (Wunderlich, and Kohler, 2001).

It is important to understand that quality initiatives cannot be explained without the explanation of quality indicators or measures because quality initiatives are just the building blocks in explaining the concept of quality, quality in long-term care settings and how long-term quality indicators take part in the deliverance of healthcare (Zimmerman et al., 2008).

Since the mid-1960s, quality assessment has been measured in terms of three concepts: structures of care, processes of care, and outcomes of care (Donabedian, 1966). Structural measures are the organizational characteristics associated with the provision of care. Process measures are characteristics of things done to and for the resident. Outcome measures are the desired states one would (or would not) like to achieve for the resident (Castle and Ferguson, 2010). Outcomes of care include changes in health status and conditions attributable to the care provided or not provided. Unlike acute care, for which successful outcomes often mean restoring patients to their level of functioning before the onset of illness, successful outcomes in long-term care are likely to be based on criteria such as maximizing quality of life and physical function in the presence of permanent, and sometimes worsening, impairment (Wunderlich & Kohler, 2001). Donabedian’s SPO approach is somewhat pervasive in the quality literature (Castle and Ferguson, 2010). In evaluating the quality of long-term care, multiple perspectives must be considered.
Application of the concept of consumer-oriented long-term care requires that the quality of long-term care be judged not only in terms of the structure, processes, and outcomes of clinical care, but also in terms of access to care, the nonmedical personal assistance services that are an important part of long-term care, and the long-term care user's quality of life. (Castle and Ferguson, 2010). Because perspectives can differ among recipients of long-term care services and between care recipients and care providers, one of the challenges is establishing priorities reflecting different perspectives (Wunderlich & Kohler, 2001).

In the article by Binstock and Spector (1997) entitled “Five Priority Areas for Research on Long-Term Care,” long-term care is assessed within priority areas for research purposes surrounding patient care objectives. According to Binstock & Spector (1997), because long-term care involves the living environment as well as treatment, quality of life requires a much greater emphasis in long-term care quality measures than in acute care, which is more focused on the impact of treatment. As mentioned earlier in the paper, the authors define quality and, more specifically, quality of life as including such components as psychological functioning, social functioning and activities, enjoyment of living environment, a sense of dignity and autonomy, and religious functioning. Binstock & Spector (1997) express, however, that measures of such components are not well developed and, therefore, it remains difficult to assess those care settings in which these aspects of quality are more of a concern. Both authors outline five priority areas for research on long-term care that go across-settings and are interdependent. They further acknowledge, that the first step in developing a research agenda on quality is to improve quality measures. (Binstock & Spector, 1997).

Binstock & Spector (1997) list the following important quality areas for research:

1. Development and Refinement of Quality-of-Care Measures
a. Communication concerns of the patient with cognitive deficits.

b. Family involvement in care difficulties, outcomes measurements, quality concerns and the function goals of the patient.

2. Cost, Demand and Quality of Care

a. Better understanding of relationship to cost and quality to help consumers to understand.

b. To make decisions about Medicaid, while healthcare officials reimburse providers based on quality of care.

3. Cost and Quality of Care Across Settings

a. Command issues and establishing relationships between investments and quality of care.

b. Providing efficiency and establishing efficacy in types of settings and investigating organizational appropriateness of care.

4. Innovations in Providing Care

a. Innovations provides low technology in providing care with converts to organizational changes.

b. Innovations may involve a breakthrough in developing new technology.

5. Managed Care and Long-Term Care

a. Completing applications of managed care organizations.

b. Submitted financial information.

c. Experimenting with a series of programs to integrate in acute and long-term care (Binstock & Spector, 1997).
As the above authors provide steps to improve quality of care, it is important to recognize that their number one step is to address communication. Additionally, we must recognize that outcomes provide results, and results can produce an action in which the action can provide a solution for quality improvements.

Therefore, understanding the communication processes that are occurring especially during the transition phase between healthcare environments, we can prepare healthcare professionals to address negative communication skills and in turn promote the utilization of positive communication skills that in turn can lead to improved quality of care in all settings including long term (Grabowski, 2007).

Not surprising, in the literature an absence of information exists regarding the communication strategies, processes and health professionals’ skills employed during the transition period between acute care and sub-acute patient transfers. Thus, understanding communication during this transition period may provide insight regarding communication as an indicator of quality of care in the long-term healthcare setting.

**Acute Care**

The World Health Organization (2012), defines acute care as “the health system components, or care delivery platforms, used to treat sudden, often unexpected, urgent or emergent episodes of injury and illness that can lead to death or disability without rapid intervention.” It is further defined including, “a range of clinical health-care functions, including emergency medicine, trauma care, pre-hospital emergency care, acute care surgery, critical care, urgent care and short-term inpatient stabilization.” Acute care is the very beginning of patient care in providing immediate treatment for all health ailments. According to Binstock & Spector (1997), acute care is the stage of care by which the patient is assessed, and quality objectives are
determined. If the patient requires additional acute care services beyond the admission stay, the hospital will act in the patient’s best interest by providing additional services to promote continuous care for the patient. To support this notion, the WHO (2012) asserts that “acute services, therefore, include all promotive, preventive, curative, rehabilitative or palliative actions, whether oriented towards individuals or populations, whose primary purpose is time-sensitive and, frequently, rapid intervention.”

The Connecticut Department and Office of Health Care Access Annual reporting (1999) further clarifies the WHO’s perspectives and, defines acute care as a level of health care in which a patient is treated for a brief but severe episode of illness, for conditions that are the result of disease or trauma, and during recovery from surgery. According to the Connecticut Department public health code that regulates hospitals, an acute care hospital is defined as a short-term hospital that has facilities, medical staff and all necessary personnel to provide diagnosis and care conditions including injuries. The Connecticut Dept of Health (1999), states that acute care sets the foundation for new admissions and aids in the discharge process for patients requiring extended services as well as those set for discharge to home with health supportive services.

When exploring quality in the post-acute care setting, the international literature sheds light on a comparison between standard of practice within the United States vs. outside of the United States. In the United States, CMS (2008) defines long-term quality as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. According to Gray, Peel, Crotty, Kurrle, Giles & Cameron (2012), internationally, short hospital lengths of stay and a high demand for post-acute care have led to new models of care for older people that offer coordinated discharge, ongoing support and often a focus on functional restoration. The literature
affirms more emphasis placed on post-acute care for the elderly - a similar model used in the
standard of United States based transitional care procedures. The term “transition care” is a
“term that encompasses such services and is defined as a set of actions designed to ensure the
coordination and continuity of healthcare as patients transfer between different levels of care and
among a diverse range of providers, services and settings” (Gray et al., 2012). Transitioning of
care is the most important communication process that occurs between healthcare settings as
well as healthcare providers and continues to be a root of disconnect, requiring further elevation.

**Transitional Care**

According to Boult, Green, Boult, Paccala, Snyder, & Leff (2009), transitional care is a
successful model of care that encompasses a broad range of services, is focused on preparing and
implementing safe and timely passage from one environment to another and is typically
delivered by nurses or APN’s. Transitional care with supplementary services, combined with
self-promotional healing gives outcomes of continuous patient improvement.

As acute care hospitals discharge patients back to the community and/or refer patients to
skilled facilities for sub-acute care and/or long-term care, a team of experts must be present for
this transition of care. It is extremely important that the hospital team of experts place the patient
in the best-case scenario in order to promote an optimal level of care (Boult, Green, Boult,
Paccala, Snyder, & Leff, 2009). Often acute care hospitals fall short in this delicate area for
numerous reasons. The reason that this area is considered so fragile is because this is where the
patient will experience an improvement of health or significant decline in health. If the team of
healthcare professionals do not place factors such as the patient, family, healthcare professionals
and/or the healthcare facilities into consideration, the patient will not be set up for securing
improvements in their health status (Boult, Green, Boult, Paccala, Snyder, & Leff, 2009).
Healthcare professionals must be proactive in proper post-acute care, and transitional care selection. The patient must be placed into an environment where care transition is promoted, proper medications are administered, and the promotion of proper healing is supported. When a patient and their care plan is not effectively on boarded into the new facility upon discharge by the acute-care hospital team, the patient can suffer detrimental health consequences. Thus, transitional planning for the patient’s journey from hospital to sub-acute/or long-term care facility is an involved task for everyone responsible for both indirect and direct patient care and requires attention (Naylor, 2012).

As older care adults continue to be hospitalized for many health reasons, transitioning from acute care to a long-term health care facility for additional treatment or recovery can be very challenging for the patient as well as the family. Roupp, Baughman & Simon (2018) state in “Expanding Clinician Practice from Acute to Subacute Care” that the need for transitional care improvement measures exists. This is addressed with respect to improved clinician rotation and educational benefits. Care transitions between hospitals and SNFs are a vulnerable time for patients. As Coleman et al (2003) defined, which has been further supported by Naylor (2012): “transitional care is a term that encompasses such services and is defined as a set of actions designed to ensure the coordination and continuity of healthcare as patients transfer between different levels of care and among a diverse range of providers, services and settings.”

The current health care climate of decreasing hospital length of stay, readmission penalties, and increasing patient complexity has made hospital care transitions an important safety concern (Ruopp et al., 2018). Given that approximately 23% of patients admitted to SNFs are readmitted to acute care hospitals within 30 days, and that these patients have increased mortality rates in risk-adjusted analyses (Burke, Whitefield, & Hittle et al, 2016; Mor, Intrator,
Feng et al., 2010), understanding the care transition process is most crucial. Not surprisingly in the healthcare arena there are direct penalties for re-admissions to acute care before thirty-days, post discharge. This thirty-day readmission for the same diagnosis results in the hospitals not being reimbursed for services rendered. As research states, “the rate of rehospitalizations from SNFs within 30 days of original discharge has increased to nearly one-fifth since 2004, and ~90% of these rehospitalizations were unplanned” (Mileski et al., 2017). Thus, this rise in thirty-day readmission is a major problem for hospitals and sub-acute facilities, and begs the research to ask, “what was the transition plan for this patient.” Often, many transitions are urgent and unplanned, patients are largely unprepared for what transpires and are often uncertain about their role (Coleman et al., 2004).

As the patient transitions from acute-care hospital to sub-acute/long-term care where the identified problem of either a success or failure of optimal patient care begins, patients, providers, and payers recognize unnecessary hospital admissions from SNFs as a deficit in quality and value. It is known that hospitals discharge an increasing number of patients to SNFs with high rates of readmission. A large percentage of readmissions from SNFs are rated as avoidable potentially within the research findings and this factor of avoidability varies between hospital and SNF staff due to associated factors and ratings (Mileski et al., 2017). According to Coleman et al. (2004), the first step to improving the quality of transitional care is to recognize and address the unique attributes of this domain of health care. This suggests that there is a need for accountability between the relationship of hospitals and SNFs.

**Subacute Care**

Subacute Care has been a term closely related to Skilled Nursing Facility (SNF). Several healthcare organizations define Subacute Care in a variety of ways. The majority of the literature
posits that Subacute Care and SNF are essentially interchangeable. Keith, Wilson, and Gutierrez (1995), however, note that there is a difference between Subacute Care and Acute Rehab services. To distinguish the two forms of treatment, rehabilitation in a skilled nursing setting has been termed subacute rehabilitation, with acute rehabilitation being the usual hospital-based variety which is based upon treatments provided. Originally conceived to build up patients so they could profit from conventional rehabilitation or as an aid in the transition after restorative care, SNF-based rehabilitation has been used increasingly as a substitute for traditional inpatient care (Keith, Wilson, and Gutierrez, 1995). U.S Dept Of Health and Human Services et al. (1994) defines subacute as managing “patients who did not meet established criteria for medically necessary acute care, but who remained in hospital beds licensed for acute care, largely due to lack of suitable alternative placements.”

According to Eagar and Innes (1992), the term ‘subacute’ in Australia describes patients whose need for health care is predicted by their functional status rather than their principal medical diagnosis.

There seems to be a consensus in the literature that subacute care represents a niche in the continuum of care between acute-hospital care and long-term, nursing home care. According to the U.S. Dept Of Health and Human Services et al. (1994) subacute care is referred to as a less costly alternative to hospital care for those patients who require intense medical supervision and therapy but are not critical enough to be in intensive care in an acute-hospital ward. Anders (1994) determined that there are several ways to break down subacute care. Short stays of 3 to 30 days in which they estimate 75 percent of their subacute care business is and in which care is either medically complex or rehabilitative; Medium stays of 31 to 90 days in which they estimate 22 percent on their subacute care business is and in which patients require both medical and
rehabilitative services; and long stays of 91 days to less than two years in which they estimate 3 percent of their subacute care business is and in which care is for catastrophic illnesses with a very slow rate of recovery (Eagar and Innes (1992).

**Home Care**

Many individual transitions from acute care to another medical care facility others are discharged to their home. Most patients as well as family prefer that their loved ones receive care within the home. Being at home provides a sanctuary environment in which the patient does not have to adapt to a new environment (Coleman et al. 2004). When receiving care within the home environment, the goal is for the patient to remain active. “Activities of Daily Living” is the goal for the patient so they can remain as active and independent with help and the assistance from licensed personnel (Coleman et al., 2004). There is an increasing number of individuals receiving care in their home which enables them to receive the care they need while living with independence and dignity (Yakerson, 2018). Home care can also be an integral component of the post-hospitalization recovery process especially during the initial weeks after discharge when the patient still requires some level of regular physical assistance (WHO, 2015). Transitional home health care (post hospitalization) can be used to empower the elderly to become more involved in managing their chronic illnesses and more confident in communicating with health care professionals (Coleman, Smith, Frank, Min, Parry, et al., 2004).

According to Home Care in Canada (2018), home care is defined as “an array of services for people of all ages, provided in the home and community setting, that encompasses health promotion and teaching, rehabilitation, support and maintenance, social adaption and integration, end of life care, and support for family caregivers.” The National Clinical Homecare Association (2011) defines homecare as “the provision of medical supplies and/or clinical services directly to
patients in the community.” Home care services, based on individual need, are provided to individuals of all ages with both acute and chronic conditions, including adults with disabilities and the frail elderly (Yakerson, 2018). While many authors provide differing definitions of home care services, the fact remains that all the authors agree of the importance and fragility of this level of care to patients and that homecare indeed starts at home.

**Communication as a Necessary Soft Skill Across the Healthcare Settings**

All along the healthcare continuum, from admittance into an acute care setting to being discharged home into the community, or a long-term facility for additional care, communication between the patient, family and healthcare professionals is key to promote quality patient care. According to Bensing (1991), communication behavior in healthcare has instrumental and effective aspects. The distinction between effective and ineffective communication is often discussed in the literature as the concept of doctor (healthcare provider)-patient dyadic communication. When a healthcare provider spends time listening to his/her patient’s concerns and responds back to the patient in a language that the patient understands, effective communication takes place which allows the transformation of information to flow freely between both parties in the dyadic relationship Bensing (1991). Each party expresses feelings and thoughts and, most importantly, the physician is more apt to have a clear understanding if the patient has received the medical information on top of the patient’s concerns. It is crucial to have open communication whether the patient is in acute care or long-term care because open lines of communication should provide clarity. According to Benzar, Hansen, Knritel et al. (2011), poor communication and unmet needs for information and education in the post-discharge setting were reported as problematic by patients, family, caregivers, and nurses in three studies. Similarly, Blackford & Street (2001) and Tallman, Greenwald, Reidenouer et al. (2012) also
report the problematic effects resulting from a lack of communication between provider and patient and its overall effects on health outcomes. While the impact of communication has been reported in the literature from the physician and patient standpoint as it relates to the impact on patient healthcare outcomes, globally communication is imperative across all parts of healthcare and amongst all healthcare professionals in order to ensure quality healthcare Blackford & Street (2001) and Tallman, Greenwald, Reidenouer et al. (2012). Interpersonal communication between healthcare staff members and professionals such as physicians, physician assistants, physical and occupational therapists, respiratory therapists, speech language pathologist and nurses, to name a few, is of the utmost importance to the deliverance of quality healthcare. Interprofessional communication happens synchronously and asynchronously (Conn et al., 2009). Synchronous genres refer to communications happening in real time such as meetings, ward rounds, handoffs, or impromptu conversations (Conn et al., 2009). Communications also happen asynchronously such as posting on white boards, through medication orders, or written progress notes (Conn et al., 2009). Communication is not only verbal and written, but it also includes body language, attitude and tone (Nadzam, 2009). Communication strategies employed is often very distinctive within different types of healthcare settings and between differing healthcare workers. But regardless of the mode of delivery used to promote communication, communication is a skill that must be developed and promoted across all healthcare setting and amongst all health care professionals and staff.

With the advent of the interprofessional educational revolution, healthcare professionals are recognizing the importance of using sound effective communication skills in order to promote teamwork and collaboration (Nadzam, 2009). Through interprofessional educational opportunities, healthcare professionals and staff are becoming increasingly comfortable and open
in acknowledging interprofessional differences such as diversity training, education, language and roles. Despite this progress, the literature continues to reflect challenges between the professions in terms of effective communication (Foronda et al., 2016).

While it is imperative that communication amongst the doctor-patient dyad exist, it is also important that communication amongst professionals exist within and across all healthcare settings in order to promote quality care for patients. In its 2011 report, the Picker Institute reported its conclusion that communication and care transitions were the two overarching themes that patients, families, providers, and experts all agreed were essential to quality patient centered care (Ruben, 2016). According to Ruben (2016) the importance of effective communication when sending and receiving messages is imperative and professionals must recognize that, “Communication, often thought of as a soft skill, encompasses the exchange and sharing of information among several key players of the healthcare team, including communications between patients/families and providers, as well as among providers collectively responsible for a patient’s care” (Nadzam, 2009). As healthcare professionals we must acknowledge that communication is foundational to ensuring an effective patient–provider partnerships. “Communication facilitating partnership” is a theme that must be constant in any interaction a patient may have with the healthcare system. (Picker Institute, 2011, pp. 6–7).

When applied to health communication, this means that communication outcomes are not easily shaped or controlled by message senders, but rather are more fundamentally guided by the predispositions and the “susceptibilities and take-into-accountabilities” of the receivers (Thayer, 1968). These dynamics are important in all communication situations, and especially in professional–lay encounters, but nowhere more so than in health communication settings, which embody all the complexity and challenge—and even greater stress—than present in most other
interpersonal settings. (Ruben, 2016). The relational dimensions of communication also may be of primary importance to patients and their families in their judgments of provider competencies and the quality of the care being provided. As mentioned previously, most patients and family members lack the knowledge necessary to assess the clinical quality of the care they receive, their evaluations emphasize relationship quality, the interpersonal communication skills and competencies of the provider, and the manner in which they are treated personally (Korsch & Negrete, 1972; Ruben, 1990). Communication in healthcare is very valuable. As patients, families and healthcare staff transmits and receives all information in the form of communication, whether it is verbal, non-verbal, face to face or simply paper information, it is important to understand that communication is the key component in the delivery of quality care in all healthcare settings and especially as patients transition from one setting to another as is the case when moving from acute care to sub-acute setting (Ruben, 2016) (Figure 2).

**Figure 2**

*Measuring Quality of Care*

![CMS framework for measurement maps to the six national priorities](image_url)
Summary

Based upon the literature reviewed, we see the emergence of what one might call a “Relationship Triad” influencing the quality of healthcare for patients between: patient acuity and setting, resources, and communication (within settings and between setting/transitioning).

Quality indicators have been recently implemented to manage quality of care and outcomes. Castle and Ferguson (2010) define quality indicators in healthcare as the performance, the process, and the outcomes of measures in quality of care. Nursing home quality indicators can provide a way to support quality assurance and improvement activities and help ensure that cost savings are based on increased efficiency and not on decreased quality of care (Karon et al, 1999).

As transitioning processes and practices play an important role in promoting quality care regardless of if they are transitioning back home, or sub-acute, or long-term healthcare setting, it is important that the process is delegated smoothly with effective communication between the acute care hospital and the discharge facility. According to Coleman and Benson (2004), since many transitions are urgent and unplanned, patients are largely unprepared for what transpires and are often uncertain about their role.

A problem presents when the quality of care is diminished during this transition from acute to long-term care by which the patient either does not improve health-wise and/or suffers effects leaving the patient in a more compromised state of health. In delivering quality from the time the patient is discharged from acute care to long-term care, time plays an important role in recovery. According to Coleman and Berenson (2004), the first step to improving the quality of transitional care is to recognize and address the unique attributes of this domain of healthcare.
Transitional care requires its own agenda and unique set of strategies to address the multiple and complex factors that affect its quality.

Based upon this review, limited research has been conducted on improving quality of care in long-term settings as well as during the transitional care planning phase. To date, researchers have narrowly focused on intervention studies to improve quality of care in nursing facilities with none reporting on multi-level interventions that comprehensively address the quality of care in nursing homes or the transition period (Tables 1 and 2). Traditionally, these existing narrowly focused studies inform multilevel intervention designed to guide clinical practice changes, implemented to improve care quality (Patton 2012).

Recognizing and appreciating that quality of care is crucial throughout the patient healthcare journey (beginning when the patient is admitted into an acute care setting, transferred to community living or into long-term care settings), healthcare professionals must ensure that effective communication exists during the transitional periods especially between acute care and long-term care, as communication is imperative to the ongoing continuity of quality care health for the patient. (Patton 2012).

Therefore, it is necessary to explore communication processes during transitions from acute care to skilled nursing facilities and determine perceived barriers and facilitators to communication (Tables 3 and 4).
## Table 1

### SNF and Patient Acuity

<table>
<thead>
<tr>
<th>Authors</th>
<th>Participants/Setting Procedures</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jennings, B. M. (2008)</td>
<td>Medical/ surgical patients in acute-care/SNF-long-term care. Cross-sectional design</td>
<td>In bivariate correlations, acuity was negatively associated with medication errors and falls, and positively correlated with infections, decubiti, complaints, and death.</td>
</tr>
<tr>
<td>Boudreaux et al. (2004)</td>
<td>1,865 patients over 1 month at a large inner-city hospital ED Patients: average age 30 years; 53% female Cross-Sectional design</td>
<td>Patients with higher acuity were more satisfied with care and perceived their throughput time more favorably; satisfaction was more closely linked to perceived throughput times than to actual throughput times or acuity.</td>
</tr>
<tr>
<td>Spector et al. (2007)</td>
<td>32 inpatient units in one SNF/hospital from 2000 to 2001; 3,418 patients Cross-Sectional design</td>
<td>Unit data were aggregated to create yearly data due to small numbers for some variables. <strong>Acuity was a significant predictor</strong> of the self-care measures of importance and understanding, and indexes of self-care symptom management.</td>
</tr>
<tr>
<td>Brennan &amp; Daly (2009)</td>
<td>Patients and Providers SNF Qualitative design</td>
<td>The attributes of acuity are severity, intensity and the pairing of acuity measurements with another concept. These attributes were organized according to Holzemer’s Outcomes Model for Health Care Research as patient-, provider- or system-related. The sub-categories of attributes identified were physical, psychological, nursing care needs, workload, complexity, case-mix, patient classification systems, urgency/triage scales and other uses.</td>
</tr>
</tbody>
</table>
### Table 2

**SNF Transitioning Processes**

<table>
<thead>
<tr>
<th>Authors</th>
<th>Participants/Setting Procedures</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>King et al. (2013)</td>
<td>Twenty –seven registered nurses from five Wisconsin SNFs Qualitative design</td>
<td>Nurses note multiple deficiencies in hospital-to-SNF transitions, with poor quality discharge communication being identified as the major barrier to safe and effective transitions. This information should be used to refine and support the dissemination of evidence-based interventions that support transitions of care, including the Interventions to Reduce Acute Care Transfers program.</td>
</tr>
<tr>
<td>Shah et al. (2009).</td>
<td>Nursing home /skilled care administrators and nursing staff. Qualitative design</td>
<td>Hospital and nursing home characteristics and interorganizational relationships were associated with nursing home administrators’ perceptions of barriers to hospital-nursing home communication in the transitioning process.</td>
</tr>
<tr>
<td>King et al. (2013).</td>
<td>Twenty –seven registered nurses from five Wisconsin SNFs Qualitative design</td>
<td>Nurses cited multiple inadequacies of hospital discharge information, including regular problems with medication orders (including the lack of opioid prescriptions for pain), little psychological or functional history, and inaccurate information regarding current health status.</td>
</tr>
</tbody>
</table>

### Table 3

**Communication Impacting Quality of Care**

<table>
<thead>
<tr>
<th>Authors</th>
<th>Participants/Setting Procedures</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bensign J.M. (1991).</td>
<td>5 wards in acute hospital care 90 patients, 105 nursing staff Observational Survey Qualitative Research</td>
<td>Found that communication behavior in healthcare has instrumental and effective aspects. The distinction between effective and ineffective communication is often discussed in the literature as the concept of doctor (healthcare provider)-patient dyadic communication.</td>
</tr>
<tr>
<td>Benzar, Hansen, Knritel et al. (2011)</td>
<td>Hospital care palliative patients Pilot study/mixed method design</td>
<td>Results showed that poor communication and unmet needs for information and education in the post-discharge setting were reported as problematic by patients, family, caregivers, and nurses in three studies.</td>
</tr>
<tr>
<td>Blackford &amp; Street (2001); Tallman et al. (2012)</td>
<td>Patients/families and care research team. Pilot descriptive/longitudinal.</td>
<td>This study reported the problematic effects resulting from a lack of communication between provider and patient and its overall effects on health outcomes.</td>
</tr>
<tr>
<td>Ruben (2016)</td>
<td>Patients, nurses, families Qualitative descriptive</td>
<td>In its 2011 report, the Picker Institute reported its conclusion that communication and care transitions were the two overarching themes that patients, families, providers, and experts all agreed were essential to quality patient-centered care.</td>
</tr>
</tbody>
</table>
Table 4

*Communication: A Barrier During Transitioning*

<table>
<thead>
<tr>
<th>Authors</th>
<th>Participants/Setting Procedures</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shah et al (2009)</td>
<td>Nursing Home Administrators and Nursing home staff</td>
<td>Communication between hospital and nursing facility is hindered by <strong>patient privacy regulations</strong> (HIPPA).</td>
</tr>
<tr>
<td>King et al (2013)</td>
<td>27 registered nurses from five Wisconsin SNFs</td>
<td>Inadequate hospital discharge information and communication had a serious negative effect on individuals and families, SNF staff, and the SNF facility. Nurses noted multiple deficiencies in hospital-to-SNF transitions, with <strong>poor-quality discharge communication being identified as the major barrier</strong> to safe and effective transitions. This information should be used to refine and support the dissemination of evidence-based interventions that support transitions of care, including INTERACT.</td>
</tr>
</tbody>
</table>

Qualitative design
Chapter III
METHODOLOGY

Research Design

The study design used in this research was a qualitative study design. The Qualitative research approach is an inductive approach that “begins with assumptions and the use of interpretive/theoretical framework that informs the study of the research problem by addressing the meaning individuals or groups ascribe to a social or human problem” (Creswell, 2014, pg 44). This designed is used when a problem needs to be explored and cannot be easily measured (Creswell, 2014). In the qualitative research approach the researcher seeks to describe and explore the topic of interest rather than test a hypothesis or make a prediction about what will be found in the research (Creswell & Creswell 2018).

Inclusion/Exclusion Criteria

To be included in the research study, participants had to be a transition team member (which includes acute care discharge managers, nursing home social workers, nurses, or directors), >18 years of age, currently employed in an acute care hospital, or long-term care facility and read and speak English. Interested individuals not meeting the identified inclusion criteria were not invited to participate / excluded from participation in the study.

Participant Recruitment

Participants were recruited from acute care hospitals and SNF settings in New Jersey using solicitation flyers. Individuals meeting the inclusion criteria were given a letter of informed consent (Appendix E) to participate in the study. Flesh-Kincaid statistics are found in Appendix F.

Access to these individuals in these healthcare settings were provided through PI’s professional network sources from PI’s current place of employment.
Pre-Screening Tool

A pre-screening tool was created by the PI and used to remove participants who did not fit the inclusion criteria of the study (Appendix G).

Interview Guide

The interview guide was constructed by the PI and contained the introduction, actual questions related to associated sub research questions, probing questions, and demographic questions. Appendix B details the interview guide for participants.

Table 5 is an Alignment Chart which displays the research questions associated with the corresponding interview guide questions and linked to the corresponding construct in Barnlund’s Transaction Model of Communication. This table illustrates the link between the study research questions, interview guide questions, and the constructions of the theoretical model used as the study lens.

Table 5

Alignment Chart

<table>
<thead>
<tr>
<th>Research Question</th>
<th>Corresponding Interview Question</th>
<th>Corresponding Construct in Barnlund’s Transaction Model of Communication</th>
</tr>
</thead>
<tbody>
<tr>
<td>RQ1: What are the transition teams’ perceived communication initiatives (processes) employed as part of the transition process from the acute care to SNF setting, in order to promote patient POC and quality of care?</td>
<td>1, 10, 12</td>
<td>perceived communication initiatives</td>
</tr>
<tr>
<td>RQ2: What are the transition teams’ perceived barriers associated with communication among the team during the patient’s transition process from acute care to SNF setting?</td>
<td>2, 13</td>
<td>perceived barriers</td>
</tr>
<tr>
<td>RQ3: What are the transition teams’ perceived pressures associated with communication among the team during the patient’s transition process from acute care to SNF setting?</td>
<td>3, 11</td>
<td>perceived pressures</td>
</tr>
<tr>
<td>RQ4: What are the transition teams’ perceived benefits associated with communication among the team during the patient’s transition process from acute care to SNF setting?</td>
<td>4</td>
<td>perceived benefits</td>
</tr>
<tr>
<td>RQ5: What are the transition teams’ perceived key acuity measures to use among the team during the patient’s transition process from acute care to SNF setting, in order to promote patient POC and quality of care?</td>
<td>5, 7, 14</td>
<td>key acuity measures</td>
</tr>
<tr>
<td>RQ6: What are the transition teams’ experiences as part of the transition team from the acute care to SNF setting?</td>
<td>6, 8, 9, 15</td>
<td>experiences</td>
</tr>
</tbody>
</table>
**Study Procedure**

Upon approval by the Seton Hall University Institutional Review Board (IRB), recruitment began (Appendix A). Potential participants were contacted through the PI’s professional network at acute care hospitals and SNF settings in New Jersey. The individuals contacted by the PI were asked to snowball the email invitation (Appendix D) and/or recommend the names and contact information of other potential participants to whom they knew that may be eligible to participate in the study. The participants were transition team members (e.g. acute care discharge managers, nursing home social workers, nurses and directors). After contact through email between the PI and potential participant and after completing the pre-screening tool (Appendix G), a formal Letter of Informed Consent (Appendix E) was sent via email to potential participants. Demographic questions were included (Appendix C). Code numbers were assigned for confidentiality purposes. Teams video conference calls were planned virtually to conduct the interview between the PI and participant.

Participants’ consent was obtained through the Letter of Informed Consent (Appendix E). The interview was conducted by the PI. Interviews were recorded with the TEAMS app on the computer. Audio recordings started for each interview and the PI took notes while the interviews were conducted. Post-interviews, participants were asked if they had any questions pertaining to the study, the topic or their involvement. Finally, participants were thanked for their time and provided contact information should they be interested in the results and follow-up of the study in the future. After the interviews were conducted, the data was transcribed verbatim. Transcripts were read and re-read for accuracy purposes and code development begin thereafter.
Data Analysis: Codes, Categories and Theme Development

For coding of the data, the researcher performed the following inductive approach: Read and reread transcripts, identified descriptive and in vivo emerging codes, organized codes in categories and thematic generation.

Transcription involves close observation of data through repeated careful listening (and/or watching), and this is an important first step in data analysis (Bailey, 2008). According to Mays & Pope (2000), this familiarity with data and attention to what is actually there rather than what is expected can facilitate realizations or ideas which emerge during analysis. Creswell describes this as the “reading and memoing stage” when he recommends identifying “major organizing ideas” or categories across all databases (Creswell & Creswell, 2018). When you apply and reapply codes QDA, you are codifying - a process that permits data to be divided, grouped, reorganized, and linked in order to consolidate meaning and developed explanation (Grbich, 2013).

Saladana, (2016) states “Researchers with smaller data sets needing just three to ten major codes and/or categories total can assign a specific-colored font to text passages that belong in the same category”. “In vivo” coding is a form of qualitative data analysis that places emphasis on the actual spoken words of the participants. This form of coding can be especially helpful when researchers interact with participants from a particular culture or microculture to help highlight how those participants use specific words or phrases in their interactions that might not otherwise be understood when using other forms of coding. In vivo coding is championed by many for its usefulness in highlighting the voices of participants and for its reliance on the participants themselves for giving meaning to the data (Saladana 2016).
For each participant, audio recordings were transcribed verbatim and reviewed by PI immediately to determine if saturation had been reached. Transcriptions were read and re-read. PI assigned emergent codes & sub codes using *in vivo* and descriptive coding (Creswell, 2013; Saldana, 2016). This study employed a two-part coding process: *decoding* to determine core meaning of a passage and *encoding* to determine which code to use and label the passage (Saldana, 2016). Codes generated by the PI were reviewed by a faculty researcher for accuracy and to meet intercoder agreement of 80 (Saldana, 2016).

After codes were obtained, the information was used to address the research questions and develop meaning from the data results and develop understanding and conclusions. The process allowed for making sense of the research, linking the results to the initial problem statement to provide significance and give support to the rationale of the study.

**Validating the Accuracy of the Interview**

To ensure that the study achieved trustworthiness measures, several criteria were established based on Lincoln and Gruba (1985) including credibility, dependability, confirmability, and transferability (Table 6).

Trustworthiness is crucial (Golafshani, 2003). Validity and reliability come from trustworthiness of the research (Seale, 1999). Validation in qualitative research is assessing the “accuracy” of the results (Creswell & Poth, 2013).
Table 6

*Trustworthiness Features of the Study*

<table>
<thead>
<tr>
<th>Feature of the Study That Were Designed to Meet the Trustworthiness Criteria</th>
<th>Study Features to Achieve the Criterion</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Credibility</strong></td>
<td>The accuracy of the findings and interpretations as viewed by stakeholders within the context</td>
</tr>
<tr>
<td></td>
<td>Prolonged engagement with the data ✓</td>
</tr>
<tr>
<td></td>
<td>Use of framework-systematic approach to data analysis ✓</td>
</tr>
<tr>
<td></td>
<td>Member checking ✓</td>
</tr>
<tr>
<td><strong>Dependability</strong></td>
<td>Concerned with instability of the findings and whether they might be influenced by the study design; also concerned with the appropriateness and transparency of decision making</td>
</tr>
<tr>
<td></td>
<td>Detailed documentation of decisions in relation to codes and categories during data analysis ✓</td>
</tr>
<tr>
<td><strong>Confirmability</strong></td>
<td>Demonstrates that the findings of a study are grounded in the data</td>
</tr>
<tr>
<td></td>
<td>Codes developed from the data rather than relying on preconceived categories ✓</td>
</tr>
<tr>
<td></td>
<td>Detailed documentation of decisions in relation to codes and categories during data analysis ✓</td>
</tr>
<tr>
<td></td>
<td>Use of verbatim quotes (invivo) to illustrate themes and categories ✓</td>
</tr>
<tr>
<td><strong>Transferability</strong></td>
<td>The extent to which the findings are relevant to other settings</td>
</tr>
<tr>
<td></td>
<td>Detailed description of the characteristics of the participants to understand the extent to which the findings are relevant to the participants’ work setting ✓</td>
</tr>
</tbody>
</table>

Note: Adapted from Lincoln and Gruba (1985)

**Summary of Data Collection Procedures**

The data collection process began with semi-structured interviews composed of main questions which include the flexibility to expand on information that emerged in the interview for the 15 interview questions. An average time of 57 minutes was used for each interview through TEAMS including the taking of field notes during interviews. Figure 3 below describes the exact process that was employed from receiving SHU IRB approval to finally establishing Intercoder agreement. (Creswell & Creswell 2018).
Figure 3

Data Collection Procedures

[Diagram showing data collection procedures with steps such as: Received SHU IRB Approval, Recruited participants using snowball sampling beginning with letter of solicitation sent to 2 transition team professionals (NJ hospital and NJ nursing home), Letter of Solicitation along with Prescreen email and consent, Met criteria? Yes?, Transcribed data one by one verbatim using Teams transcription function, Started audio recording using Teams record function, conducted interview and took notes, Assigned code number for confidentiality, Sent demographic info form and scheduled interview, Read and re-read transcripts, Began code development, followed by category development, and thematic analysis, Established intercoder agreement for codes, categories, and thematic analysis.]
Chapter IV

RESULTS

Introduction

This chapter provides the demographic and qualitative data findings.

Demographic Characteristics of the Sample

Seven individuals participated in this study (Table 7). The age of participants was categorized into 4 categories (Figure 4). The seven participants were categorized into 4 predetermined categories of age. One participant was identified as falling within the 18-30 age range, two participants fell within the 31-40 age range, two participants fell within the 41-50 age range and two participants fell into the 51-60 age. All participants identified as females. Figure 5 highlights participants years in the profession. Figure 6 highlights the education level of the participants which included three at the Bachelors level and four at the Masters. Three types of professional job titles were identified by the participants: Case-manager (4), Director of Social Worker (2) and Case-Manager Coordinator (1).

Table 7

Demographics of the Participants

<table>
<thead>
<tr>
<th>Participant #</th>
<th>Profession</th>
<th>Years in profession</th>
<th>Job title</th>
<th>Years in current position</th>
<th>Highest level of education</th>
<th>Gender</th>
<th>Age Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Case-manager (MSN)</td>
<td>19</td>
<td>Case-manager coordinator</td>
<td>18</td>
<td>Masters</td>
<td>Female</td>
<td>41-50</td>
</tr>
<tr>
<td>2</td>
<td>Social worker</td>
<td>10</td>
<td>Director of Social Services</td>
<td>4</td>
<td>Masters</td>
<td>Female</td>
<td>31-40</td>
</tr>
<tr>
<td>3</td>
<td>Case-manager (MSN)</td>
<td>15</td>
<td>Case-manager</td>
<td>7</td>
<td>Masters</td>
<td>Female</td>
<td>31-40</td>
</tr>
<tr>
<td>4</td>
<td>Case-manager (BSN)</td>
<td>5</td>
<td>Case-manager</td>
<td>5</td>
<td>Bachelors</td>
<td>Female</td>
<td>18-30</td>
</tr>
<tr>
<td>5</td>
<td>Social worker</td>
<td>25</td>
<td>Social worker</td>
<td>5</td>
<td>Bachelors</td>
<td>Female</td>
<td>51-60</td>
</tr>
<tr>
<td>6</td>
<td>Case-manager (MSN)</td>
<td>25</td>
<td>Case-manager</td>
<td>14</td>
<td>Masters</td>
<td>Female</td>
<td>51-60</td>
</tr>
<tr>
<td>7</td>
<td>Social worker</td>
<td>13</td>
<td>Director of Social Work</td>
<td>13</td>
<td>Bachelors</td>
<td>Female</td>
<td>41-50</td>
</tr>
</tbody>
</table>
Figure 4

Age of Participants

![Bar chart showing age distribution of participants. The bars represent the frequency of participants in age groups 18-30, 31-40, 41-50, and 51-60.]
Figure 5

*Years in Profession of Participants.*
Qualitative Data Findings

According to Saldana (2016), a theme can be an outcome of coding, categorizing, or analytic reflection. A theme may be identified at the manifest level (directly observable in the information) or at the latent level (underlying the phenomenon). Themes are also described. The analytic goals are to develop an overarching theme from data corpus, or an integrative theme that weaves various themes together into a coherent narrative (Saldana 2016). The following six themes were developed from the participants interview data:

1. The transition teams’ perceived communication initiatives include written and verbal communication employed among the teams to exchange vital information can be
challenging and impact the transfer status. Insufficiency, and clarity issues are important to identify early within the transfer process. Daily meetings help eliminate obstacles and establish key issues within patient medical history.

2. The transition teams’ perceived barriers center around skilled care facility requirements. Additionally, there are time delays, diverse issues with patient needs, and problems with information retrieval. While management routine communication practices help improves transfer process.

3. The transition teams’ perceived pressures are the facility’s time sensitivity issues, limited facility policy and communication between acute care setting and the skilled care facility leading to errors such as improper discharge.

4. The transition teams’ perceived benefits centers around an effective team base plan of care, person centered care and creating patient initial assessment which fosters teamwork for the patient overall health and quality of life.

5. The transition teams perceived key acuity measures include measuring discharge planning by employing HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) which is designed to enhances scores on internal set criteria as well as enhances scores on external criteria which allows the team to concentrate on facility policies for smoother transitions and reduces the length of stay by positively impacting the effectiveness of patient satisfaction in the transition process.

6. The transition teams’ experiences are often stressful but communication practices, education and knowledge, trial, and error support better decision-making outcomes.
The following section provides insight into how the themes were reflected in the participants’ data as categories that emerged from their narrative responses.

**Research Question 1 Data**

The interview data for IQ1 is found in Table 8. Upon reviewing the data, several codes emerged in the participants’ responses to RQ1 which asked: “What are the transition teams’ perceived communication initiatives (processes) employed as part of the transition process from the acute care to SNF setting, in order to promote patient POC and quality of care?” IQ1 asked “How would you describe the communication initiatives processes employed as a part of the transition process from acute care to skilled nursing facility setting at your institution?” The seven participants identified “verbal communication” and “written communication” as the prominent codes which emerged. Participant 1 and Participant 2 stated that a verbal report, conferences, and initial assessments help eliminate communication barriers by sharing background information amongst all team members.
Table 8

RQ1 Interview Data (IQ1)

The interview data for IQ10 is found in Table 9. Upon reviewing the data, several codes emerged in the participants’ responses to RQ1 which asked: “What are the transition teams’ perceived communication initiatives (processes) employed as part of the transition process from the acute care to SNF setting, in order to promote patient POC and quality of care?” IQ10 asked “Can you describe the impact communication may have during the transition process on the patient’s quality of care (POC development and implementation) in SNF?” The seven participants identified “challenging” and “impactful” as the prominent codes. Participant 4 and Participant 5 stated that it is challenging and critical taking all team members views into consideration.
Table 9

*RQ1 Interview Data (IQ10)*

The interview data for IQ12 is found in Table 10. Upon reviewing the data, several codes emerged in the participants’ responses to RQ1 which asked: “What are the transition teams’ perceived communication initiatives (processes) employed as part of the transition process from the acute care to SNF setting, in order to promote patient POC and quality of care?” IQ12 asked “Can you describe how your institution identifies communication barriers when patient is transitioning from acute-care to SNF?”

The seven participants identified “insufficiency” and “clarity issues” as the prominent codes. Participant 4 and Participant 5 state lack of documentation and not communicating with the facility as causing major problems.
### Table 10

**RQ1 Interview Data (IQ12)**

**RQ1 Interview Data**

<table>
<thead>
<tr>
<th>RQ1: What are the transition teams’ perceived communication initiatives (processes) employed as part of the transition process from the acute care to SNF setting, in order to promote patient POC and quality of care?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CODES</strong></td>
</tr>
<tr>
<td>Insufficiency</td>
</tr>
<tr>
<td>Clarity issues</td>
</tr>
<tr>
<td>P4 “For starters, lack of documentation and insufficient communication on our end is ongoing issues that we face as a team daily when the patient is transitioning from the hospital to nursing facility.”</td>
</tr>
<tr>
<td>P2 Difficulty</td>
</tr>
<tr>
<td>P3 Uncertainty</td>
</tr>
<tr>
<td>P5 “If the acute care facility does not communicate and be clear, to us on the skilled care level, the diagnosis and the patient insurance can cause a major problem”</td>
</tr>
</tbody>
</table>

### Table 11

**RQ1 Interview Data Codes**

**RQ1 Interview Data**

<table>
<thead>
<tr>
<th>RQ1: What are the transition teams’ perceived communication initiatives (processes) employed as part of the transition process from the acute care to SNF setting, in order to promote patient POC and quality of care?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CODES</strong></td>
</tr>
<tr>
<td>Verbal communication</td>
</tr>
<tr>
<td>Written communication</td>
</tr>
<tr>
<td>Challenging impactful</td>
</tr>
<tr>
<td>Insufficiency</td>
</tr>
<tr>
<td>Clarity issues</td>
</tr>
<tr>
<td><strong>CATEGORIES</strong></td>
</tr>
<tr>
<td>• Verbal Communication</td>
</tr>
<tr>
<td>• Insufficiency and clarity issues affects transition process.</td>
</tr>
<tr>
<td>• Written communication</td>
</tr>
<tr>
<td>• Decision making process can be challenging but it is impactful</td>
</tr>
</tbody>
</table>
Emergent Categories based on RQ 1

Upon reviewing the data from the codes in Table 11, four categories emerged in the participants’ responses to RQ1 which asked: “What are the transition teams’ perceived communication initiatives (processes) employed as part of the transition process from the acute care to SNF setting, in order to promote patient POC and quality of care?” The 7 participants identified that “verbal communication” is an important factor for transition teams in order to promote the patient POC and quality of care. Verbal communication appeared 24 times in the transcript for all 7 participants combined making it the most prominent theme to emerge.

The second predominant theme to emerge was identified as “Insufficiency and clarity issues affect transition process” specifically appearing 16 times. Also, important, the emergent theme “Written communication” was seen 15 times within the transcript. “Decision-making process” appeared 4 times. The understanding is that verbal communication is more vital as an emergent theme because without this, there can be no clarity in the decision-making process (Figure 7).
Figure 7.

**RQ1 Emergent Thematic Categories**

Note: Categories to the following research question: What are the transition teams’ **perceived communication initiatives** (processes) **employed** as part of the transition process from the acute care to SNF setting, in order to promote patient POC and quality of care?

**Research Question 2 Data**

The interview data for IQ2 is found in Table 12. Upon reviewing the data, several codes emerged in the participants’ responses to RQ2 which asked: What are the transition teams’ perceived barriers associated with communication among the team during the patient's transition process from acute care to SNF setting? IQ2 asked “How would you describe, if any, the barriers to communication among the team during the patient's transition process from acute care to SNF
setting at your institution?” The seven participants identified “diverse issues, patient, facility, environment, retrieval of information, diverse team perspective and disagreements” as the prominent codes. Participant 3 and Participant 5 state that urgent reports and information can be miscommunicated which can cause further confusion for team members.

Table 12

*RQ2 Interview Data (IQ2)*

The interview data for IQ13 is found in Table 13. Upon reviewing the data, several codes emerged in the participants’ responses to RQ2 which asked: What are the transition teams’ perceived barriers associated with communication among the team during the patient's transition process from acute care to SNF setting? IQ13 asked “Can you describe how management at your institution become involved when a communication barrier exists?” The seven participants identified “assistance, meetings and messages” as the prominent codes. Participant 3 and
Participant 7 state that the management team is involved by having meetings about the discharge process.

Table 13

*RQ2 Interview Data (IQ13)*

<table>
<thead>
<tr>
<th>RQ2: What are the transition teams’ perceived barriers associated with communication among the team during the patient’s transition process from acute care to SNF setting?</th>
</tr>
</thead>
<tbody>
<tr>
<td>CODES</td>
</tr>
<tr>
<td>IQ13 Can you describe how management at your institution become involved when a communication barrier exists?</td>
</tr>
<tr>
<td>Assistance</td>
</tr>
<tr>
<td>Meetings</td>
</tr>
<tr>
<td>Messages</td>
</tr>
<tr>
<td>P3 “Yes, our management team is very involved in discharge.”</td>
</tr>
<tr>
<td>P7 “Management actually have meetings with everyone in team.”</td>
</tr>
<tr>
<td>P1 reporting issues</td>
</tr>
<tr>
<td>P5 urgent Messages</td>
</tr>
</tbody>
</table>
Emergent Categories based on RQ 2

Upon reviewing the data from the codes in Table 14, five categories emerged in the participants responses to RQ2 which asked: “What are the transition teams’ perceived barriers associated with communication among the team during the patient's transition process from acute care to SNF setting?”

The 7 participants identified that “Diverse team perspectives” is an important factor for the transition teams during the patient’s transition from acute care to SNF setting and this appeared 11 times in the transcript for all 7 participants combined making it the most prominent
theme to emerge. The second predominant theme to emerge was identified as “Diverse issues with patient needs” specifically appearing 4 times. “Problems with information retrieval and management communication practices” also emerged as emergent themes. Also, while important the emergent theme “facility time delays” was only seen 3 times within the transcript. The understanding is that “Diverse team perspectives” is more vital as an emergent theme because without this theme, the teams would not be able to identify perceived barriers during the patient transition process (Figure 8).

**Figure 8**

*RQ2 Emergent Thematic Categories*

![Diagram showing frequency of categories: Facility time delays 3, Problems with information retrieval 4, Management routine communication practices help improve transfer process 4, Diverse issues with patient needs 4, Diverse team perspectives 11.*

Note: Categories to the following research question:” What are the transition teams’ perceived barriers associated with communication among the team during the patient's transition process from acute care to SNF setting?
Research Question 3 Data

The interview data for IQ3 is found in Table 15. Upon reviewing the data, several codes emerged in the participants’ responses to RQ3 which asked:” What are the transition teams’ perceived pressures associated with communication among the team during the patient's transition process from acute care to SNF setting?” IQ3 which asked: “How would you describe the pressures associated with communication among the team during the patient's transition process from acute care to SNF setting, at your institution?” The seven participants identified “time sensitivity (busy), uncertainty in transition process and inappropriate dismissal” as the prominent codes. Participant 6 and Participant 2 state that uncertainty and nurses are too busy to provide report due to time constraints hinders the transfer process.

Table 15

RQ3 Interview Data (IQ3)
The interview data for IQ11 is found in Table 16. Upon reviewing the data, several codes emerged in the participants’ responses to RQ3 which asked: “What are the transition teams’ perceived pressures associated with communication among the team during the patient's transition process from acute care to SNF setting? IQ11 asked: “Does your institution have identified procedures and/or policies to guide patients’ transitions from acute-care to SNF and vice versa? If so, can you tell me about them?” The seven participants identified “facility policies procedures” and “limited communication” as the prominent codes. Participant 1 and Participant 5 state there is a 24 to 48 hospital policy for admissions and creates pressure due to lack of communication.

Table 16

**RQ3 Interview Data (IQ11)**
Table 17

RQ3 Interview Data Codes

<table>
<thead>
<tr>
<th>CODES</th>
<th>CATEGORIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time sensitivity (busy)</td>
<td>• Improper discharge/placement</td>
</tr>
<tr>
<td>Uncertainty in transition process</td>
<td>• Time sensitivity issues</td>
</tr>
<tr>
<td>Inappropriate dismissal</td>
<td>• Limited facility policy surrounding transition process</td>
</tr>
<tr>
<td>Facility Policies Procedures</td>
<td>• Limited communication between acute care and SNF</td>
</tr>
<tr>
<td>Limited communication</td>
<td></td>
</tr>
</tbody>
</table>

Emergent Categories based on RQ 3

Upon reviewing the data from Table 17, four categories emerged in the participants’ responses to RQ3 which asked: “What are the transition teams’ perceived pressures associated with communication among the team during the patient's transition process from acute care to SNF setting?” (Figure 9).

The 7 participants identified that “Improper discharge placement” is an important factor for transition teams during the patient’s transition from acute care to SNF setting and this appeared 15 times for all 7 participants combined making it the most prominent theme to emerge. The
second predominant theme to emerge was identified as “time sensitivity issues” which appeared 7 times. Also, while important the emergent theme “Limited facility policy surrounding transition process” was only seen 6 times within the transcript and “limited communication” appeared 5 times. The understanding is that “Improper discharge placement” is more vital as emergent theme because improper discharge affects communication among the team during the patient’s transition process from acute care to SNF setting (Figure 9).

**Figure 9**

*RQ3 Emergent Thematic Categories*

Note: Categories to the following research question:” What are the transition teams’ perceived pressures associated with communication among the team during the patient’s transition process from acute care to SNF setting?”
Research Question 4 Data

The interview data for IQ4 is found in Table 18. Upon reviewing the data, several codes emerged in the participants’ responses to RQ4 which asked: “What are the transition teams’ perceived benefits associated with communication among the team during the patient's transition process from acute care to SNF setting? IQ4 asked: “Can you describe any potential benefits associated with communication among the team during the patient's transition process from acute care to SNF setting at your institution?” The seven participants identified “fosters teamwork, patient overall health and creating patient initial assessment” as the prominent codes. Participant 4 and Participant 3 state communication is a benefit when it is clear and concise.

Table 18

RQ4 Interview Data (IQ4)
Table 19

RQ4 Interview Data Codes

RQ4 Interview Data

| RQ4: What are the transition teams' perceived benefits associated with communication among the team during the patient's transition process from acute care to SNF setting? |
|---|---|
| **CODES** | **CATEGORIES** |
| Fosters teamwork | Team based plan of care |
| Patient overall health | Person centered care |
| Creating patient initial assessment | |

Emergent Categories based on RQ 4

Upon reviewing the data from Table 19, two categories emerged in the participants responses to RQ4 which asked: “What are the transition teams' perceived benefits associated with communication among the team during the patient's transition process from acute care to SNF setting?” The 7 participants identified that “Team based plan of care” is an important factor transition teams during the patient’s transition from acute care to SNF setting appeared 14 times for all 7 participants combined making it the most prominent theme to emerge. The last predominant theme to emerge was identified “Person centered care” which appeared 2 times. Also important is the emergent theme “Team based plan of care.” The understanding is that team-based plan of care is more vital as emergent theme because Team based plan of care is
perceived as a benefit among the team during the patient’s transition process from acute care to SNF setting (Figure 10).

**Figure 10**

*RQ4 Emergent Thematic Categories*

Note: Categories to the following research question: What are the transition teams’ perceived benefits associated with communication among the team during the patient’s transition process from acute care to SNF setting?”
Research Question 5 Data

The interview data for IQ5 is found in Table 20. Upon reviewing the data, several codes emerged in the participants’ responses to RQ5 which asked: “What are the transitions teams’ perceived key acuity measures to use among the team during the patient’s transition process from acute care to SNF setting, in order to promote patient POC and quality of care?” IQ5 asked: “Can you describe the key acuity measures used among the team during the patient’s transition process from acute care to SNF setting, at your institution?” The seven participants identified “policies, criteria and quality” as the prominent codes. Participant 4 and Participant 6 state that patient quality of care and hospital measures is based on proper placement for patient transition.

Table 20

RQ5 Interview Data (IQ5)

<table>
<thead>
<tr>
<th>RQ5: What are the transitions teams’ perceived key acuity measures to use among the team during the patient’s transition process from acute care to SNF setting, in order to promote patient POC and quality of care?</th>
<th>CODES</th>
</tr>
</thead>
</table>
| IQ5 Can you describe the key acuity measures used among the team during the patient’s transition process from acute care to SNF setting, at your institution? | Policies/ Criteria
Quality
P4 “Acute hospital setting, figuring out proper placement of patients is based on the acute care measures hospital policies and my facility.”
P6 evaluate patient’s quality of care.
P5 “Here at my skilled facility we follow steps to determine if the patient meets criteria such as does the patient have Medicaid or some type of health care or long term care insurance.” |
The interview data for IQ7 is found in Table 21. Upon reviewing the data, several codes emerged in the participants’ responses to RQ5 which asked: “What are the transitions teams’ perceived key acuity measures to use among the team during the patient's transition process from acute care to SNF setting, in order to promote patient POC and quality of care?” IQ7 asked: “Can you describe the impact patient acuity level may have on communication strategies employed when transitioning a patient from acute-care to SNF?” The seven participants identified “smoother and higher impacts” as the prominent codes to emerge. Participant 2 and Participant 1 state that if the patient is alert with no cognitive deficits, this will allow a smoother transition process.

Table 21

RQ5 Interview Data (IQ7)
The interview data for IQ14 is found in Table 22. Upon reviewing the data, several codes emerged in the participants’ responses to RQ5 which asked: “What are the transitions teams’ perceived key acuity measures to use among the team during the patient’s transition process from acute care to SNF setting, in order to promote patient POC and quality of care?” IQ14 asked: Can you describe how your institution measures patient outcomes?” The seven participants identified “readmission rates, length of stay and external scores” as the prominent codes to emerge. Participant 1 and Participant 6 state that the Press Ganey and length of stay are some of the measurements we used for discharge planning.

Table 22

*RQ5 Interview Data (IQ14)*
Table 23

*RQ5 Interview Data Codes*

Note: Categories to the following research question:” What are the transitions teams perceived key acuity measures to use among the team during the patient’s transition process from acute care to SNF setting, in order to promote patient POC and quality of care?”

Emergent Categories based on RQ 5

Upon reviewing the data in Table 23, three categories emerged in the participants responses to RQ5 which asked: “What are the transition teams’ perceived key acuity measures to use among the team during the patient’s transition process from acute care to SNF setting, in order to promote patient POC and quality of care?”

The 7 participants identified that “enhanced scores on internal set criteria” is an important factor transition teams during the patient’s transition from acute care to SNF setting appeared 24
times for all 7 participants combined making it the most prominent theme to emerge. The second predominant theme to emerge was identified as “enhanced scores external set criteria” which appeared 17 times. Also important is the emergent theme “positively impacts overall transition” which appeared 6 times within the transcript. The understanding is that Enhanced scores on internal set criteria is more vital as emergent theme because key acuity measures allows the team to have a set goal during the patient’s transition process from acute care to SNF setting (Figure 11).

**Figure 11**

*RQ5 Emergent Thematic Categories*
Research Question 6 Data

The interview data for IQ6 is found in Table 24. Upon reviewing the data, several codes emerged in the participants’ responses to RQ6 which asked: “What are the transition teams’ experiences as part of the transition team from the acute care to SNF setting?” IQ6 which asked: “Can you describe your experiences as part of the transition team from the acute care to SNF setting, at your institution?” The seven participants identified “stressful” and “better with communication” as the prominent codes. Participant 6 and Participant 7 state that experiences are stressful but the more communication the better due to different aspects of the job.

Table 24

<table>
<thead>
<tr>
<th>RQ6</th>
<th>Interview Data (IQ6)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RQ6:</strong> What are the transition teams’ experiences as part of the transition team from the acute care to SNF setting?</td>
<td><strong>CODES</strong></td>
</tr>
</tbody>
</table>
| IQ6: Can you describe your experiences as part of the transition team from the acute care to SNF setting, at your institution? | Stressful
Better with Communication

P5 “My experience came from Hospice. Each circumstance or case has definitely has challenges, and there’s stress in the role that I play when all the team members don’t communicate effectively.”

P6 “So my experience is currently very stressful because of the sudden influx of patients due to Covid and the acuity of the patients. So we have the administration telling us to discharge the patient not knowing the patient status of health acuity so we have to speak for the patient that this patient is not ready for discharge.”

P7 “The more communication they get, the better, so some of the aspects that I used to do ‘cause every job is different of course however, the same title now have been kind of given another department’. I’ve taken on that big piece in this Coronavirus era. Since you really can’t see the family members we’re only visually seeing them through zoom and such on the phone.” |
The interview data for IQ8 is found in Table 25. Upon reviewing the data, several codes emerged in the participants’ responses to RQ6 which asked: “What are the transition teams’ experiences as part of the transition team from the acute care to SNF setting?” IQ8 asked: “Can you describe the type of specialized training you have had in transition planning?” The seven participants identified “educational training and certificates” as the prominent codes. Participant 6 and Participant 3 state that background built on education, med surg and having a national certification are all essential for the discharge process.

Table 25

*RQ6 Interview Data (IQ8)*

The interview data for IQ9 is found in Table 26. Upon reviewing the data, several codes emerged in the participants’ responses to RQ6 which asked: “What are the transition teams’ experiences as part of the transition team from the acute care to SNF setting?” IQ9 asked: “Do
you believe transition team members’ clinical experience impacts decision making when transitioning a patient from acute care to SNF? Please explain your response.” The seven participants identified “knowledge” and trial and error” as the prominent codes. Participant 1 and Participant 2 state that knowledge and clinical experience have a positive impact in gaining resources.

**Table 26**

*RQ6 Interview Data (IQ9)*

The interview data for IQ15 is found in Table 27. Upon reviewing the data, several codes emerged in the participants’ responses to RQ6 which asked: “What are the transition teams’ experiences as part of the transition team from the acute care to SNF setting?” IQ15 asked? “Can you identify who in your institution is responsible in determining outcome measures?” The seven participants identified “performance improvement members and team members knowledge” as the prominent codes. Participant 6 and Participant 1 state the teams who are responsible for
outcome measures are performance improvement, quality department and all executive administration.

**Table 27**

*RQ6 Interview Data (IQ15)*

<table>
<thead>
<tr>
<th>RQ6: What are the transition teams’ experiences as part of the transition team from the acute care to SNF setting?</th>
</tr>
</thead>
<tbody>
<tr>
<td>CODES</td>
</tr>
<tr>
<td>IQ15 Can you identify who in your institution is responsible in determining outcome measures?</td>
</tr>
<tr>
<td>Performance Improvement Members</td>
</tr>
<tr>
<td>Team Members</td>
</tr>
<tr>
<td>P6 “So the people who are responsible for the outcome measures are the performance improvement people who do quality improvement, performance improvement.”</td>
</tr>
<tr>
<td>P1 “We have a quality Department performance improvement Department and all executive administration looks at um outcome measures for like upper management”.</td>
</tr>
<tr>
<td>P4 Upper management</td>
</tr>
<tr>
<td>P2 Team members</td>
</tr>
<tr>
<td>P5 Staff managers</td>
</tr>
</tbody>
</table>
Table 28

RQ6 Interview Data Codes

**RQ6 Interview Data**

<table>
<thead>
<tr>
<th>CODES</th>
<th>CATEGORIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stressful</td>
<td>Stressful experiences improve with communication</td>
</tr>
<tr>
<td>Better with Communication</td>
<td>Education/knowledge is important</td>
</tr>
<tr>
<td>Educational training</td>
<td>Trial and error informs learning</td>
</tr>
<tr>
<td>Certifications</td>
<td></td>
</tr>
<tr>
<td>Knowledge</td>
<td></td>
</tr>
<tr>
<td>Trial and error</td>
<td></td>
</tr>
<tr>
<td>Performance Improvement Members</td>
<td></td>
</tr>
<tr>
<td>Team Members</td>
<td></td>
</tr>
</tbody>
</table>

**Emergent Categories based on RQ6**

Upon reviewing the data from Table 28, three categories emerged in the participants responses to RQ6 which asked: “What are the transition teams’ experiences as part of the transition team from the acute care to SNF setting?” The 7 participants identified that “trial and error informs learning” is an important factor transition teams during the patient’s transition from acute care to SNF setting which appeared 22 times in the transcripts for all 7 participants combined making it the most prominent theme to emerge. The second predominant theme to emerge was identified as “education/knowledge is important” which appeared 17 times. Also important is the emergent theme “Stressful experiences improve with communication” which
appeared 9 times within the transcript. The understanding is that the teams’ trial and error informs learning is a driving force based on experiences as part of the transition team from the acute care to SNF setting (Figure 12).

**Figure 12**

*RQ6 Emergent Thematic Categories*

Note: Categories to the following research question: What are the transition teams’ experiences as part of the transition team from the acute care to SNF setting?”
Thematic Analysis

The thematic analysis consists of the six research questions and accompanying answers to those questions based on the thematic analysis (Tables 29 and 30). The research questions were answered using the Interview questions posed to the participants of the study from the corresponding interview guide which corresponds to the constructs in Barnlund’s Transaction Model of Communication. The reasoning behind the construction of the questions is strategically to both adhere to the theoretical model and establish a flow in the interview to develop themes from the participants’ responses.

Table 29

*Thematic Analysis for RQs 1-3*

<table>
<thead>
<tr>
<th>RQ</th>
<th>Final Thematic Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>RQ1 = IQ 1, 10, 12</td>
<td>The transition teams’ perceived communication initiatives include written and verbal communication employed among the teams to exchange vital information can be challenging and impact the transfer status. Insufficiency, and clarity issues are important to identify early within the transfer process. Daily meetings help eliminate obstacles and establish key issues within patient medical history.</td>
</tr>
<tr>
<td>RQ1. What are the transition teams’ perceived communication initiatives (processes) employed as part of the transition process from the acute care to SNF setting, in order to promote patient POC and quality of care?</td>
<td></td>
</tr>
<tr>
<td>RQ2 = IQ 2, 13</td>
<td>The transition teams’ perceived barriers center around skilled care facility requirements. Additionally, there are time delays, diverse issues with patient needs, and problems with information retrieval. While management routine communication practices helps improves transfer process.</td>
</tr>
<tr>
<td>RQ2. What are the transition teams’ perceived barriers associated with communication among the team during the patient’s transition process from acute care to SNF setting?</td>
<td></td>
</tr>
<tr>
<td>RQ3 = IQ 3, 11</td>
<td>The transition teams’ perceived pressures are the facility’s time sensitivity issues, limited facility policy and communication between acute care setting and the skilled care facility leading to errors such as improper discharge.</td>
</tr>
<tr>
<td>RQ3. What are the transition teams’ perceived pressures associated with communication among the team during the patient’s transition process from acute care to SNF setting?</td>
<td></td>
</tr>
</tbody>
</table>
Table 30

*Thematic Analysis for RQs 4-6*

<table>
<thead>
<tr>
<th>RQ</th>
<th>Final Thematic Analysis</th>
</tr>
</thead>
</table>
| RQ4 = IQ 4  
RQ4. What are the transition teams' perceived benefits associated with communication among the team during the patient's transition process from acute care to SNF setting? | The transition teams' perceived benefits centers around an effective team base plan of care, person centered care and creating patient initial assessment which fosters teamwork for the patient overall health and quality of life. |
| RQ5 = IQ 5, 7, 4  
RQ5. What are the transition teams' perceived key acuity measures to use among the team during the patient's transition process from acute care to SNF setting, in order to promote patient POC and quality of care? | The transition team's perceived key acuity measures include measuring discharge planning by employing HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) which is designed to enhances scores on internal set criteria as well as enhances scores on external criteria which allows the team to concentrate on facility policies for smoother transitions and reduces the length of stay by positively impacting the effectiveness of patient satisfaction in the transition process. |
| RQ6= IQ 6, 8, 9, 15  
RQ6. What are the transition teams' experiences as part of the transition team from the acute care to SNF setting? | The transition teams' experiences are often stressful but communication practices, education and knowledge, trial and error support better decision-making outcomes. |
Chapter V
DISCUSSION

3 Facets of Barnlund’s Framework Revisited in Context of Results

In the context of the results of this study, Barnlund’s framework reveals new insight (Figure 13). Barnlund’s Framework provided three facets which supports the different types of communication processes that was explored throughout this study. The first facet is Information transfer between sender and receiver. Barnlund’s states that giving and receiving messages is reciprocal. This means that both communicators (the sender and the receiver) are responsible of the effect and effectiveness of the communication (Barlund, 1970). The second facet Barriers as “Noise” is the environmental of noise which are a part of the message. The communication barriers represent in the environmental noise is displayed between the team members. The last facet is Interpersonal vs. Intrapersonal Communication and the subset are Verbal and Non-Verbal Behavioral Cues. Barnlund broke down communication into two types: Intrapersonal: encoding/decoding one’s own messages (e.g. reading a book). Interpersonal: encoding/decoding another person’s messages (e.g. teamwork). Behavioral Cues: are categorized by Verbal (i.e. orally spoken) and Nonverbal (e.g. gestures, body cues). Barnlund’s transactional model of communication provided a realistic view in how team members communicate with one another, whether its by oneself in trying to make sense of information that was received or communicating amongst the teams such a daily meetings to make sense in how communication affects the information transfer between sender and receiver, for the patient’s transitional process, or how Barriers as “Noise” effects the transitional process when the team tries to communicate with one another and how Interpersonal vs. Intrapersonal Communication Verbal
and Non-Verbal Behavioral Cues interferes with the encoding and decoding process when information is received.

**Information transfer between sender and receiver.** Figure 13 reveals Barnlund’s initial framework with the additions of the results interpreted through the lens of the 3 facets of barriers as noise, interpersonal vs. intrapersonal communication and verbal and non-verbal communication.

**Barriers as Noise.** There are six barriers to communication identified in the results that act as the “noise” in this diagram. The six barriers that acts as noise are: Team disagreements, Facility time delays, Clarity issues, limited facility policy and protocols surrounding transition process, limited communication between acute care and skilled nursing facility and lack of access. Without effective communication amongst the team members, quality of care and plan of care will affect the patient’s transfer status from acute care to skilled care nursing facility.
Figure 13

*Barnlund’s Transactional Model of Communication Revisited in the Context of the Results through the lens of the 3 Facets.*

Note: Adapted from Barnlund (1970). Diagram includes the added barriers of “noise,” concepts of interpersonal and intrapersonal communication and verbal and non-verbal communication.

**Intrapersonal and Interpersonal Communication.** In revisiting Barnlund’s framework in the context of the results, Figure 14 was created based on the two forms of communication that Barnlund speaks of: intrapersonal and interpersonal. The shape of the visual is purposeful because of the description of communication according to the theorist who describes it as dynamic, continuous, circular, etc.
**Verbal Communication.** Communication can be verbal in nature (Table 31). Participant 1 spoke on how a universal transfer form and verbal reports allows the teams to make a decision in the transfer process from acute care to skilled care nursing facility. This process includes written and verbal communication which is used in a sequential manner and is a plan that the facility has adopted to access the patient for the transition process. Participant 2 also stated that the “initial assessment is conducted by all team members, which describes the written process similarly to Participant 1.
The verbal and written process that the teams employ allows them to evaluate the patient, which they can create plan of care that is a necessary component of the verbal, written and oral process for the team members. Participant 4 states how lack of documentation and communication is ongoing which infers a face-to-face communication conversation as being described here. Participant 6 states that group conversation with the team members, patient and family members is essential in the planning process. Participant 6 refers to group discussion which is one of the steps in the transition process.

Table 31

**Verbal Behavioral Cues**

<table>
<thead>
<tr>
<th>Verbal Cues</th>
<th>Transcript Interview Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Written:</td>
<td>“Um, well what we do is, um, we have something called a universal transfer form with all the pertinent information of where they're going, or level of care, um insurance information, um, diagnosis, a family contact and things like that. Also, a &quot;verbal report is given by the nurse to the receiving arm&quot; non acute care where we facility.” [Participant 1]</td>
</tr>
<tr>
<td>Reports/memos</td>
<td>“Each discipline will do an initial assessment of background and share that information amongst each other, and then we continue on with following the patient through daily rounding and on the social worker plays a significant role as I'm doing mediation between the team members.” [Participant 2]</td>
</tr>
<tr>
<td>Emails</td>
<td>“For starters, lack of documentation and communication on our end is ongoing issues that we face as a team daily when the patient is transitioning from the hospital to nursing facility.” [Participant 4]</td>
</tr>
<tr>
<td>Illustrations</td>
<td>“Um, OK, so patient and family. I consider them as partners in the discharge planning process and therefore the discussion should be with the patient initially and also with the family. Because of COVID, the family feels that they haven't been part of the decision planning and they feel that they don't know what's happening with the patient, and they're very, very much concerned.” [Participant 6]</td>
</tr>
<tr>
<td>Fax</td>
<td></td>
</tr>
<tr>
<td>Oral:</td>
<td></td>
</tr>
<tr>
<td>Face to face speaking</td>
<td></td>
</tr>
<tr>
<td>Telephone conversation</td>
<td></td>
</tr>
<tr>
<td>Group discussions</td>
<td></td>
</tr>
<tr>
<td>Meetings</td>
<td></td>
</tr>
<tr>
<td>Speeches</td>
<td></td>
</tr>
</tbody>
</table>

(Mohaparra, 2013)
**Non-Verbal Communication.** Communication can be non-verbal in nature (Table 32).

Participant 3’s reaction to this form of non-verbal communication infers to the patient family members eye contact as they receive the information from the team member. Participant 6 infers that non-verbal communication such as body movement displays signifies discomfort and frustration from the lack of help from team members.

**Table 32**

*Non-Verbal Behavioral Cues*

<table>
<thead>
<tr>
<th>Non-Verbal Cues</th>
<th>Transcript Interview Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye contact (winking, eye rolling)</td>
<td>“We will give the patient and family a choice. They look around and see where they would like their loved one to go. And we reach out to the SNF and we send them our referral.” [Participant 3]</td>
</tr>
<tr>
<td>Hand gestures (squeezing of hands)</td>
<td>“Sometimes the nurses are too busy and they are not able to give us the time that we need.” [Participant 6]</td>
</tr>
<tr>
<td>Foot position</td>
<td></td>
</tr>
<tr>
<td>Torso position</td>
<td></td>
</tr>
<tr>
<td>Arm gestures</td>
<td></td>
</tr>
<tr>
<td>Head position (tilted left or right)</td>
<td></td>
</tr>
<tr>
<td>Leg position</td>
<td></td>
</tr>
<tr>
<td>(Mohaparra, 2013)</td>
<td></td>
</tr>
</tbody>
</table>

**Themes 1-6 Interpreted with the Literature**

The themes can be further understood when they are juxtaposed against other studies in the literature (Tables 33, 34, and 35). Theme 1 explains that verbal and written communication is essential for the teams to exchange vital information. According to Benzar et al., poor communication is reported as problematic which effects communication. The goal is to have better quality of care. According to King et al. (2003) and Besign, (1990) Inadequate hospital information, poor quality discharges makes effective communication between the referring acute
care and skilled nursing facility may be an indicator of quality healthcare which is indicative of Theme 2.

Table 33

*Themes 1-2 Interpreted with the Literature*

<table>
<thead>
<tr>
<th>Theme</th>
<th>Findings juxtaposed with literature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theme 1</td>
<td>The transition teams' perceived communication indicators include written and verbal communication employed among the teams to exchange vital information can be challenging and impact the transfer status. Insufficiency, and clarity issues are important to identify early within the transfer process. Daily meetings help eliminate obstacles and establish key issues within patient medical history. Results showed that poor communication and unmet needs for information and education in the post-discharge setting were reported as problematic by patients, family, caregivers, and nurses in three studies. Benzar, Hansen, Knitiel et al. (2011). Effective communication is key for the provision of quality healthcare (Benzar et al. 2011).</td>
</tr>
<tr>
<td>Theme 2</td>
<td>The transition teams’ perceived barriers center around skilled care facility requirements. Additionally, there are time delays, diverse issues with patient needs, and problems with information retrieval. While management routine communication practices help improve process. Inadequate hospital discharge information and communication had a serious negative effect on individuals and families, SNF staff, and the SNF facility. King et al. (2013). Nurses noted multiple deficiencies in hospital-to-SNF transitions, with poor-quality discharge communication being identified as the major barrier to safe and effective transitions. This information should be used to refine and support the dissemination of evidence-based interventions that support transitions of care, including INTERACT. King et al. (2013). Thus, effective communication between the referring acute care unit and the skilled nursing facility is of paramount importance and the degree or level of effective communication during this transition period may be an indicator of quality healthcare (Bensign, 1990).</td>
</tr>
</tbody>
</table>

Themes 3 and 4 are now compared in relation to the literature. For Theme 3, “time sensitivity factor is a major concern which affects communication.” According to Agarwal, (2011), Blackford et al (2001), Boudreaux (2004) and King et al. (2012), time sensitivity issues, lack of communication, higher acuity and poor-quality discharge communication has been identified as a major barrier to safe and effective transitions regarding to the result of time sensitivity communication inefficiency.
Theme 4 effective teamwork results in a clear decision process and full transparency whereby the patients’ health care needs are met. According to Barlund, 1970 & Ruben (2016), understanding how we can adapt our communication so that all experts, families and patient agreed that communication creates dialogue amongst all.

Table 34

Themes 3-4 Interpreted with the Literature

<table>
<thead>
<tr>
<th>Theme</th>
<th>Findings juxtaposed with literature</th>
</tr>
</thead>
</table>
| Theme 3 The transition teams’ perceived pressures are the facility’s time sensitivity issues, limited facility policy and communication between acute care setting and the skilled care facility leading to errors such as improper discharge. | U.S. hospitals waste over 12 billion annually as a result of time sensitivities and communication inefficiency among care providers (Agarwal et al. 2011). 
This study reported the problematic effects resulting from a lack of communication between provider and patient and its overall effects on health outcomes. (Blackford & Street 2001; Taliman et al. 2012)
Patients with higher acuity were more satisfied with care and perceived their throughput time more favorably, satisfaction was more closely linked to perceived throughput times than to actual throughput times or acuity (Boudreaux et al. 2004)
Nurses note multiple deficiencies in hospital-to-SNF transitions, with poor quality discharge communication being identified as the major barrier to safe and effective transitions. This information should be used to refine and support the dissemination of evidence-based interventions that support transitions of care, including the Interventions to Reduce Acute Care Transfers program (King et al. 2013). |
| Theme 4 The Transition teams’ perceived benefits centers around an effective team base plan of care, person centered care and creating patient initial assessment which fosters teamwork for the patient overall health and quality of life. | Unlike the interactive model, which suggests that participants alternate positions as sender and receiver, the transaction model suggests that we are simultaneously senders and receivers. This is an important addition to the model because it allows us to understand how we are able to adapt our communication—for example, a verbal message in the middle of sending it based on the communication we are simultaneously receiving from our communication partner (Bamlund, 1970).
In its 2011 report, the Picker Institute reported its conclusion that communication and care transitions were the two overarching themes that patients, families, providers, and experts all agreed were essential to quality patient-centered care. (Ruben, 2016)
We don’t just communicate to exchange messages; we communicate to create relationships, form intercultural alliances, shape our self-concepts, and engage with others in dialogue to create communities’. (Bamlund, 1970). |

According to Zhang & Grabowski 2004, Binstock et al. (1997), Donabedian (1998,) Kane (et al., 2003) and Lievesley agree that policies and procedures improve the quality of nursing homes, which set the foundation for providing quality patients center around improving the healthcare assessment which is indicative of Theme 5. The goals are focus on structure process and outcomes which increases the likelihood of improving the quality of the patient. The ultimate goal is to ensure quality of care by understanding the patient activity level.

For Theme 6, “Team collaboration is essential for a critical learning process,” the literature embodies how team members work together to create a learning environment that is
conducive to the patient recovery process, by providing optimal care, securing improvements in health status and planning for the patients journey from hospital to sub-acute or long-term facility is an involved task for everyone responsible for indirect ad direct care of the patient.

### Table 35

**Themes 5-6 Interpreted with the Literature**

<table>
<thead>
<tr>
<th>Theme</th>
<th>Findings juxtaposed with literature</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme 5</strong></td>
<td>The transition team’s perceived key acuity measures include measuring discharge planning by employing HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) which is designed to enhances scores on internal set criteria as well as enhances scores on external criteria which allows the team to concentrate on facility policies for smoother transitions and reduces the length of stay by positively impacting the effectiveness of patient satisfaction in the transition process. According to Zhang &amp; Grabowski (2004), Congress passed the Nursing Home Reform Act (NHRA) as a part of the Omnibus Budget Reconciliation Act of 1987 with the goal of improving the quality of care in nursing homes through greater government regulation. Binstock &amp; Spector (1997), Donabedian (1988), Kane et al., (2003), and Liwesley et al. (2018) overall agree and suggest providing quality to patients centers around improving the healthcare assessment, providing proper management, structure, process and outcomes to increase the likelihood of improving the quality of the patient. Each patient has individual goals dependent upon several factors, including disease state, length of stay, and therapeutic intervention. Every patient has an individual background with different requirements which set the plan of care, reliant on such mentioned factors (Binstock &amp; Spector, 1997).</td>
</tr>
<tr>
<td><strong>Theme 6</strong></td>
<td>The transition teams’ experiences are often stressful but communication practices, education and knowledge, trial and error support better decision-making outcomes. As acute care hospitals discharge patients back to the community and/or refer patients to skilled facilities for sub-acute care and/or long-term care, a team of experts must be present for this transition of care. It is extremely important that the hospital team of experts place the patient in the best-case scenario in order to promote an optimal level of care. (Boutil, Green, Boutil, Paccala, Snyder, &amp; Leff 2009). If the team of healthcare professionals do not place factors such as the patient, family, healthcare professionals and/or the healthcare facilities into consideration, the patient will not be set up for securing improvements in their health status (Boutil, Green, Boutil, Paccala, Snyder, &amp; Leff. 2009). When a patient ad their care plan is not effectively onboarded into the new facility upon discharge by the acute-care hospital team, the patient can suffer detrimental health consequences. Thus, transitional planning for the patients journey from hospital to sub-acute/or long-term care facility is an involved task for everyone responsible for both indirect and direct patient care and requires attention (Naylor 2012).</td>
</tr>
</tbody>
</table>

### The Interplay of Management and Transition Team Members

Management has always been a part in engaging with the workers to help solve many problems within organizations. Inside of acute care and skilled care nursing, the role of management has been limited. As seen within the context of the participants’ transcripts, management helps improve transfer process 4 times, which suggests that management is not that much involved in the transitioning process. Also seen in the participants transcripts is that the majority of tasks that were performed were self-directed amongst the social workers and case-
managers. Social workers and case-managers are forced to act as leaders and critical thinkers, while less than often, management intervenes when policies/procedures are not followed by the transitional teams. Daily meetings provide updates on the patient conditions and help determine what place of action is necessary to implement into creation of the plan of care. Also, meetings present opportunities for staff to express their concerns which help and empower the team members with meaningful and obtainable goals for the teams to reach together as a collective team especially in absence of management. It is not unusual as team members work together to solve problems especially if the lack of direction from management is not actively part of the transition process.

The Role of Transparency in Communication

When a multi-disciplinary approach is employed, the team comes together to communicate successful outcomes for the patient. The acute care setting must provide all necessary documents to the skilled care nursing facility, in order for the healthcare team to conduct a proper health assessment to determine if the patient meets criteria. Taking the correct steps from the beginning assures that the entire team from acute care and skilled care facility setting are mindful that their decisions affect the creation of the plan of care as well as the patient’s quality of life. As seen both in the literature and in the participants’ transcripts, there are so many barriers to communication, when the patient transfers from acute care to skilled care nursing facility. To eliminate such barriers as time sensitivity issues, lack of access to patient information and team disagreements is vital. That is why it is important that the patient’s family and or guardian is involved in the transition process because this facilitates an open dialogue for all parties, in which everyone could provide feedback and make a realistic and comprehensive
decision based on the needs of the patient. Successful outcomes are based on honesty and achievable outcomes for the patient. Clarity issues must be identified before the patient transitions to skilled care facility in order to provide quality of care. Again, the team must communicate amongst one another about any disagreements prior to the transfer to eliminate any possible uncertainties that might hinder the transitional process for the patient.

**Knowledge and Experience Matter**

The role of knowledge and experience matter which allow the healthcare team to make sound decisions when the patient transitions from acute care to skilled care nursing facility. All team members’ education consists of college in their designated specialty area as well as on-going continuing education classes and certifications which enable the teams to become more knowledgeable. Education is an ongoing process which brings a wealth of information to all of the transitional team members. Experience is based on repetition; the more transition one does, the better decision making occurs thereafter. The more successful patient transitions the team member completes, the more likely the patient will benefit from successful outcomes. Education and experience should always be based on a collective team process, whereby experienced team members educate the less experienced team members. This creates an environment where the team member with less experience learns new valuable skills which enhances learning which is conducive to them to success. Policies and procedures are mandatory because it forces the team members to be held accountable for their actions which promotes a sense of awareness to avoid potential mistakes.
The Impact of COVID-19 on the Acute Care and Skilled Care Transitioning Process

COVID-19 has affected the healthcare system since March of 2020 and has impacted patients and workers in both acute care and skilled nursing facilities. According to the team members who were interviewed for this current study, COVID-19 placed an additional barrier to the transition process from acute care to skilled nursing facilities. COVID-19 has been documented in many US nursing homes leading to a high number of deaths among residents (Adalja, Toner, & Inglesby, 2020: Bedford et al., 2020). As of May 21, 2020, at least 35,000 deaths were reported from nursing homes or other long-term care facilities in the US (Adalja, Toner, & Inglesby, 2020: Bedford et al., 2020). These deaths represent 42% of deaths due to COVID-19 in the 38 states reporting this information. Therefore, the data reported here must be taken in light of the additional barriers placed on healthcare due to COVID.

Implications for Practice

Based upon the current study findings transition team members may benefit from continued training which further develops knowledge, practice mentorship, team building, strengthens relationships, builds trust, as well as through the introduction of defined policies and procedures that can help ensure communication transparency between the members of the healthcare teams. Environments that support open dialogue amongst all persons involved in person centered care can minimize potential communication barriers even in a pandemic situation such as COVID.
Study Limitations

Limited generalizability of findings and potential for inherent biases such as social desirability bias and acquiescence bias exist within this study. Social desirability bias may exist because the team members may prefer others to view them favorably with respect to socially acceptable values, behaviors, beliefs, and opinions and this would take place within the context of the interview questioning. Also, acquiescence bias, also known as agreement bias, may exist whereby the team members could tend to select a positive response or indicate a positive connotation more often without considering the content of the question or how they really feel.

Future Explorations

A future study could consider utilizing a longitudinal case study design to explore change over time. Additionally, surveying a larger sample of transition team members and exploring potential differences across the United States, national and internationally, and across diverse practices settings based upon facility size, mission, and vision.
Chapter VI

CONCLUSION

Healthcare professionals must be proactive in promoting effective and efficient transition care for all persons. Ensuring effective written and verbal communication, adherence to policies and procedures, the addressing of time sensitivity issues, and the setting of realistic goals for the patient and team collaboration are all important components to ensuring a positive transitioning process.

All healthcare professionals must recognize the active role they must play in ensuring effective communication to promote a patient’s quality of life before, during and after their transition from acute care to skilled nursing facility.
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APPENDIX A

IRB Approval to Conduct Research
November 19, 2020

Marrizzia Oxford
Seton Hall University

Re: Study ID#2021-145

Dear Marrizzia:

The Research Ethics Committee of the Seton Hall University Institutional Review Board reviewed and approved your research proposal entitled, “Exploring Communication Processes During Transitions from Acute Care to Skilled Nursing Facilities and Perceived Barriers to Communication” as resubmitted. This memo serves as official notice of the aforementioned study's approval as exempt. If your study has a consent form or letter of solicitation, they are included in this mailing for your use.

The Institutional Review Board approval of your research is valid for a one-year period from the date of this letter. During this time, any changes to the research protocol, informed consent form or study team must be reviewed and approved by the IRB prior to their implementation.

You will receive a communication from the Institutional Review Board at least 1 month prior to your expiration date requesting that you submit an Annual Progress Report to keep the study active, or a Final Review of Human Subjects Research form to close the study. In all future correspondence with the Institutional Review Board, please reference the ID# listed above.

Sincerely,

Mara Podvey
Associate Professor
Co-Chair, Institutional Review Board

Phyllis Hansell, EdD, RN, DNAP, FAAN
Professor
Co-Chair, Institutional Review Board

Office of the Institutional Review Board
Presidents Hall · 400 South Orange Avenue · South Orange, New Jersey 07079 · Tel: 973.275.4654 · Fax 973.275.2978 · www.shu.edu
WHAT GREAT MINDS CAN DO
APPENDIX B

Interview Guide
1. How would you describe the communication initiatives (processes) employed as part of the transition process from the acute care to SNF setting, at your institution? (RQ1)

2. How would you describe, if any, the barriers to communication among the team during the patient’s transition process from acute care to SNF setting, at your institution? (RQ2)

3. How would you describe the pressures associated with communication among the team during the patient’s transition process from acute care to SNF setting, at your institution? (RQ3)

4. Can you describe any potential benefits associated with communication among the team during the patient’s transition process from acute care to SNF setting, at your institution? (RQ4)

5. Can you describe the key acuity measures used among the team during the patient’s transition process from acute care to SNF setting, at your institution? (RQ5)

6. Can you describe your experiences as part of the transition team from the acute care to SNF setting, at your institution? (RQ6)

7. Can you describe the impact patient acuity level may have on communication strategies employed when transitioning a patient from acute-care to SNF? (RQ5)

8. Can you describe the type of specialized training you have had in transition planning? (RQ6)

9. Do you believe transition team members’ clinical experience impacts decision making when transitioning a patient from acute-care to SNF? Please explain your response. (RQ6)

10. Can you describe the impact that communication may have during the transition process on the patient’s quality of care (POC development and implementation) in SNF? (RQ1)

11. Does your institution have identified procedures and/or policies to guide patients’ transitions from acute-care to SNF and vice versa? If so, can you tell me about them? (RQ3)

12. Can you describe how your institution identifies communication barriers when patient is transitioning from acute-care to SNF? (RQ1)

13. Can you describe how management at your institution become involved when a communication barrier exists? (RQ2)

14. Can you describe how your institution measures patient outcomes? (RQ5)

15. Can you identify who in your institution is responsible in determining outcome measures? (RQ6)
APPENDIX C

Demographic Questionnaire
1. What is your current profession? (please select all that apply)
   a) Case-manager (RN / BSN / MSN)
   b) Social worker
   c) Physician
   d) Nurse Practitioner
   e) Health Care Administrator
   f) Health Educator
   g) Physician Assistant
   h) Other_________________

2. How long have you worked in your profession?
   _______years

3. What is your current job title?
   Title:______________________

4. How long have you worked in your current position?
   _______years

5. What is the highest level of education you have completed?
   a) High School
   b) Associates degree
   c) Bachelors degree
   d) Masters degree
   e) Graduate or professional school
   f) Other_______

6. What is your gender?
   a) Male
   b) Female
   c) Other/Prefer not to say

7. What is your age range?
   a) 18-30    b) 31-40    c) 41-50
   d) 51-60    e) 61-69    f) 70+
APPENDIX D

Email Letter of Solicitation
to Potential Participants
Dear Health Care Professional,

My name is Marrizzia Oxford. I am a PhD student at the School of Health and Medical Sciences at Seton Hall University in the Department of Interprofessional Health Sciences & Health Administration. I am kindly requesting your participation in a doctoral research study that I am conducting titled: *Exploring Communication Processes During Transitions from Acute Care to Skilled Nursing Facilities and Perceived Barriers to Communication*.

This research study, which will begin in the month of November 2020, seeks to explore the communication processes during the transitioning of the aging adult from Acute Care to Skilled Nursing Facilities with the focus on perceived communication barriers.

The study involves a virtual interview (roughly 30-60 minutes) and completing basic demographic information. Participation is completely voluntary and you may withdraw from the study at any time.

Participation involves completing the interview using the Microsoft Teams video conference system on your preferred computer in your preferred quiet location. If you are interested in participating in this study, please email me at marrizzia.oxford@student.shu.edu to set up a day and time for your virtual interview.

If you know of any individuals who are employed as transition team members (e.g. acute care discharge members, nursing home social workers, nurses or directors) and who are currently employed in an acute care hospital or long-term care facility in the US and are 18 years of age or older and who read and speak English, please share this Letter of Solicitation with them.

If you have any questions please do not hesitate to ask. I look forward to hearing from you.

Thank you,

Marrizzia Oxford, MPA, BA
Doctoral Student, Seton Hall University
marrizzia.oxford@student.shu.edu
APPENDIX E

Letter of Informed Consent

(Exclusively Performed Online version)
Informed Consent Form

**Title of Research Study:** Exploring Communication Processes During Transitions from Acute Care to Skilled Nursing Facilities and Perceived Barriers to Communication

**Principal Investigator:** Marrizza Oxford, MPA, BA (doctoral student)

**Department Affiliation:** Seton Hall University, Department of Interprofessional Health Sciences and Health Administration

**Sponsor:** This research is supported by the Department of Interprofessional Health Sciences and Health Administration at the School of Health and Medical Sciences at Seton Hall University

**Brief summary about this research study:**
The following summary of this research study is to help you decide whether or not you want to participate in the study. You have the right to ask questions at any time. In the United States, more than 1.5 million adults live in nursing homes and this number is expected to double by 2050 (Johnson, Pope joy & Radina, 2010). Effective communication between the healthcare professionals who refer individuals from an acute care setting to a skilled nursing facility can be challenging and ultimately impact individuals’ transfer status and plan of care (POC) implementation.

**Purpose of the research study:**
The purpose of this study is to explore the communication initiatives (processes) employed as part of the transition process from the acute care to long-term care setting, in order to promote patient POC and quality of care. You are being asked to take part in this research study because you are employed as a transition team member in an acute care hospital or long-term care facility in the U.S. (e.g. acute care discharge member, nursing home social worker, nurse or doctor) and are above the age of 18.

**What you will be asked to do:**
You will be asked to participate in a virtual interview through Microsoft Teams on your computer in a quiet location and complete several demographic questions. It is expected that the interview will take between 30-60 minutes on a day of your choosing and the audio will be recorded for transcribing purposes. The interview does not require you to meet with the PI in-person. A sample of the open-ended questions that may be asked of you is the following: *Can you describe the type of specialized training you have had in transition planning?*

**Your rights to participate, say no or withdraw:**
Participation in this research is voluntary. You can decide to participate or not to participate. You can choose to participate in the research study now and then decide to leave the research at any time. Your choice will not be held against you. The person in charge of the research study can remove you from the research study without your approval due to non-compliance with the study procedures.

**Potential benefits:** The main benefit of participation is to contribute your expertise and knowledge in the field of transition planning for older adults moving from acute care to skilled nursing facilities.

**Potential risks:**
The risks associated with this study are minimal in nature and appropriate steps will be taken to ensure the privacy of the audio recordings from the interview.

Please return the signed consent form via email prior to the start of the interview to the PI at marrizza.oxford@student.shu.edu
Informed Consent Form

Confidentiality and privacy:
Efforts will be made to limit the use or disclosure of your personal information. This information may include the research study documents or other source documents used for the purpose of conducting the study. We cannot promise complete secrecy. Organizations that oversee research safety may inspect and copy your information. This includes the Seton Hall University Institutional Review Board who oversees the safe and ethical conduct of research at this institution.

This interview is being hosted by Microsoft TEAMS and involves a secure connection. Your email address, which may be used to contact you post-interview, will be stored securely on a password protected computer only accessible by the research team. The results of the research study may be published, but your name will not be used. By signing below, you are granting permission for the PI to record the interview by audio-tape. Your name will be recorded with the interview tape and be listened to by the PI and/or the PI’s faculty advisor. The tapes will be stored in the PI’s private home office computer and will be destroyed within three years after the completion of data collection.

Data sharing:
Data collected from this study will not be shared with anyone outside of the study team.

Cost and compensation:
You will not be responsible for any of the costs or expenses associated with your participation in this study. There is no payment for your time to participate in this study.

Conflict of interest disclosure:
The principal investigator and members of the study team have no financial conflicts of interest to report.

Contact information:
If you have questions, concerns, or complaints about this research project, you can contact the principal investigator (Marrizzia Oxford) at (marrizzia.oxford@student.shu.edu), the PI’s faculty advisor (Genevieve Zipp) at Genevieve.zipp@shu.edu or the Seton Hall University Institutional Review Board (“IRB”) at (973) 761-9334 or irb@shu.edu.

I hereby consent to participate in this research study.

______________________________  ______________________________
Signature of participant  Date

______________________________
Printed name of participant

______________________________  ______________________________
Signature of person obtaining consent  Date

Marrizzia Oxford

______________________________
Printed name of person obtaining consent

Please return the signed consent form via email prior to the start of the interview to the PI at marrizzia.oxford@student.shu.edu
APPENDIX F

Flesch-Kincaid Readability Statistics for Letter of
Informed Consent
APPENDIX G

Pre-Screening Tool

**Are you:**
- part of the transition team (nurse, acute-case-manager, long-term care-social worker, healthcare professional or management) at your organization that transitions patients from acute-care to skilled care nursing facility settings? Yes or no?
- over 18 years of age? Yes or no?
- proficient speaking the English language? Yes or no?
- have worked in your current position for at least one year? Yes or no?

If you have answered **YES** to all the above questions, please read the letter of consent below. If you agree (consent) to participate in this study and would like to arrange a time for your interview, please provide an email address in the field stating email address and then hit the submit button below and the researcher will contact you via email.

**Consent form**
Email address __________________ [Submit button]
APPENDIX H

Dissertation Oral Defense Form
DISCUSSION OF DISSENT FORM

DOCTORAL CANDIDATE’S NAME: Marrizza Oxford

PROJECT TITLE: Exploring Communication Processes During Transitions from Acute Care to Skilled Nursing Facilities and Perceived Barriers to Communication

ORAL DEFENSE DATE: March 8, 2021

I HAVE PARTICIPATED IN THE ABOVE-NAMED STUDENT’S ORAL DEFENSE OF HIS/HER DISCUSSION STUDY AND MY EVALUATION IS AS FOLLOWS:

DISCUSSION COMMITTEE CHAIR: Genevieve Pinto Zipp

I evaluate the student’s presentation as follows: PASS X __ FAIL __

COMMITTEE MEMBER SIGNATURE: ____________________________

DISCUSSION COMMITTEE MEMBER: Annette Kirchegger

I evaluate the student’s presentation as follows: PASS __ X __ FAIL __

COMMITTEE MEMBER SIGNATURE: ____________________________

DISCUSSION COMMITTEE MEMBER: Rev. Msgr. Gerard McCarren

I evaluate the student’s presentation as follows: PASS __ X __ FAIL __

COMMITTEE MEMBER SIGNATURE: ____________________________
APPENDIX I

Dissertation Defense Approval Form
DISSEPTION DEFeNSe APPROVAL FORM

DOCTORAL CANDIDATE’S NAME: Marrizza Oxford

PROJECT TITLE: Exploring Communication Processes During Transitions from Acute Care to Skilled Nursing Facilities and Perceived Barriers to Communication

I HAVE REVIEWED THE “NEAR FINAL” VERSION OF THE ABOVE-NAMED STUDENT’S DISSERTATION MANUSCRIPT AND MY SIGNATURE PROVIDES SUPPORT THAT THE STUDENT’S WORK IS SUFFICIENT TO PROCEED TO THE ORAL DEFENSE OF THE STUDY.

DISSERT. COMMITTEE CHAIR: Genevieve Pinto Zipp

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What great minds can do.